Mental Health Situational Analysis: South Africa

Updated Final Report v0.4

8 May 2024

national planning
commission

The Presidency
REPUBLIC OF SOUTH AFRICA

DISCLAIMER: The views expressed in this report are that of the authors based on their research and analysis, and do not reflect the view of the National Planning Commission.

List of Acronyms

ACE	Adverse Childhood Experience
APC	Adult Primary Care
ART	Antiretroviral Therapy
ARVS	Antiretroviral
BAS	Basic Accounting System
CAMH	Child and Adolescent Mental Health Services
CAPI	Computer Assisted Personal Interviews
CBO	Community Based Organisation
CBT-E	Cognitive Behaviour Therapy for the treatment of eating disorders
CCPT	Community Clinical Psychiatrist Team
CDC	Centre for Disease Control
CES-D	Center for Epidemiological Studies – Short Depression Scale
CHC	Community Health Centre
CHW	Community Health Workers
CMHS	Community Mental Health Services
COD	Cause of Death
COVID-19	Coronavirus Disease of 2019
DBE	Department of Basic Education
DHA	Department of Home Affairs
DHIS	District Health Information System
DMHST	District Mental Health Services Team
DOH	Department of Health
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development

DSM	Diagnostic and Statistical Manual
ECD	Early Child Development
EDRWeb	Electronic Drug-resistant Tuberculosis Register
EHS	Emergency Health Services
ELA	Early Life Adversity
EML	Essential Medicines List
EMS	Emergency Medical Services
FPD	Foundation of Professional Development
GAD	Generalised Anxiety Disorder
GAD-7	Generalised Anxiety Disorder Survey
GHS	General Health Survey
HCW	Healthcare Worker
HIV/AIDS	Human Immunodeficiency Virus/ Acquired immunodeficiency syndrome.
HPRS	Health Patient Registration System
HRC	Human Rights Council
HST	Health System Trust
IDR	Integrated Desk Research
IMHSI	Improving Mental Health Service Integration
LCSP	Lead Client Service Partner
LGBTQ+	Lesbian, Gay, Bi-sexual, Transgender, Queer and Plus Community
MHCA	Mental Health Care Act 17 of 2002
MHCP	Mental Health Care Plan
MHCU	Mental Health Care Users
MHPF	South African National Mental Health Policy Framework and Strategic Plan 2013–2020
MHRB	Mental Health Review Boards
MHTAC	Mental Health Technical Advisory Subcommittee
MHTAT	Mental Health Technical Advisory Task Team

MNS	Mental, Neurological and Substance use
NCD	Non-Communicable Disease
NDOH	National Department of Health
NDP	National Development Plan
NGCT	Non-governmental Community Team
NGO	Non-Government Organisation
NHC	National Health Council
NHI	National Health Insurance
NHISSA	National Health Information Systems Committee of South Africa
NiDS	National Income Dynamic Survey
NPC	National Planning Commission
NQF	National Qualification Framework
NSP	National Strategic Plan
OECD	Organization for Economic Co-operation and Development
OPD	Out-patient department
OT	Occupational Therapist
PDOH	Provincial Department of Health
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PERSAL	Personal Administration System
PHC	Primary Health Care
PHCT	Primary Health Care Team
PHQ-9	Patient Health Questionnaire
PMB	Prescribed Minimum Benefits
PMHP	Perinatal Mental Health Project
PMO	Project Management Office
PMR	Primary Market Research
PNDS	Postnatal Depression Support Association of South Africa

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PPE	Personal Protective Equipment
PRIME	Programme for Improving Mental Health Care
PTSD	Post-Traumatic Stress Disorder
ROI	Return on Investment
SADAG	South African Depression and Anxiety Group
SADHS	South Africa Demographic and Health Surveys
SAFMH	South African Federation for Mental Health
SAMHAM	South Africa Health Advocacy Movement
SANHANES	South African National Health and Nutrition Examination Survey
SAPHRA	South African Health Products Regulatory
SAPS	South African Police Service
SASH	South African Stress and Health Survey
SDOH	Social Determinants of Health
SME	Subject Matter Expert
STG	Standard Treatment Guidelines
SYM	Speak Your Mind
TB	Tuberculosis
TIER	Three Integrated Electronic Registers
UHC	Universal Health Care
USD	United Stated Dollar
VAT	Value Added Tax
WBOT	Ward-Based Outreach Teams
WHO	World Health Organisation

EXECUTIVE SUMMARY

Amidst South Africa's multifaced health challenges, mental health emerges as a pressing concern, affecting nearly 16% of the population according to 2016 statistics. This issue is compounded by the quadruple burden of disease, which includes both communicable and non-communicable illnesses. The socio-economic landscape, marked by factors such as income inequality and stigma, exacerbates mental health challenges, particularly highlighted during events like the COVID-19 pandemic. Despite efforts to integrate mental health services into primary healthcare, disparities persist, with severe shortages of mental health professionals and limited budget allocation. Notably, the National Development Plan (NDP) review in 2020 revealed insufficient attention to mental health in Chapter 10: Healthcare. Recognising this gap, the National Planning Commission (NPC), in collaboration with the Department of Planning, Monitoring, and Evaluation (DPME), initiated a Situational Analysis of Mental Health to address the urgent need for mental health reform in South Africa. This analysis was aimed to provide insights into prevalence, service accessibility, policy impact, and data availability, aligning in with the NDP's vision for comprehensive healthcare reform.

METHODOLOGY This situational analysis used a mix of primary and secondary data collection methods to gather information from various sources. Initially, existing research and data sets were reviewed to understand mental health prevalence, service providers, policy changes, and data quality. Reputable journals and government databases including the District Health Information System (DHIS) served as key sources of information. In addition to reviewing existing information, new data was also collected through interviews with key mental health stakeholders across South Africa. These stakeholders included academics, government officials, healthcare workers, and representatives from NGOs. Qualitative data, like interview transcripts and written reports, was analysed to identify common themes and patterns. Quantitative data, like numbers and statistics, was analysed using spreadsheets to understand prevalence of mental health issues and how resources are distributed. Both quantitative and qualitative findings from both types of data collection was combined to get a complete picture of the mental health situation in South Africa. This thorough approach yielded valuable insights for informing mental healthcare policies and service delivery enhancements across the nation.

INSIGHTS INTO MENTAL HEALTH PREVELANCE IN SOUTH AFRICA

Studying mental health within a population requires key metrics like incidence and prevalence to understand the burden of disease. Information on incidence and prevalence is critical for developing targeted interventions aimed at preventing new cases or mitigating the impact of existing ones. While there is an array of studies on incidence and prevalence of mental health issues in South Africa, they are focused on a particular sample of the population and often differ in their methodologies used to determine the presence of symptoms of mental health issues. This variability in methodologies makes it challenging to conduct robust trend analysis in mental health issues, as different populations and methodologies yield disparate findings.
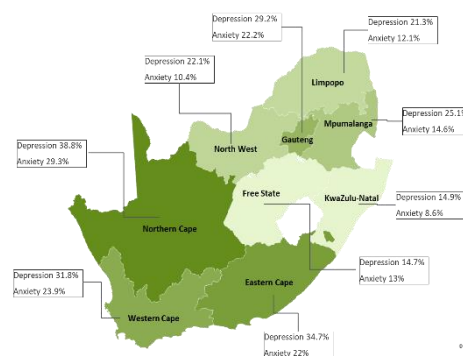
Depression and anxiety consistently emerge as the most prevalent mental disorders in South Africa, affecting a significant portion of the population. For instance, the renowned South African Health and Stress (SASH) Study conducted in 2003 to 2004 provided valuable insights into the prevalence of anxiety and mood disorders among South Africans. The study, which sampled 4,351 individuals, revealed that 15.8% of the population would experience an anxiety disorder, while 9.8% would encounter mood disorders over their lifetime. Similarly, the Global Burden of Disease report in 2016 highlighted that 15.9% of South Africans experienced a mental health issue, indicating a substantial burden. More recent studies, such as the one conducted by Wits University in 2022, have further underscored the prevalence of depression symptoms, revealing that approximately 25.7% of the population experiences symptoms associated with depression.

"At any given time, point, people experiencing household hunger have higher levels of depressed mood than people not experiencing household hunger."

Understanding the demographics most susceptible to mental health issues is vital for identifying priority groups and tailoring interventions based on specific socioeconomic and demographic variables. Research indicates that certain populations face heightened risk, such as women during the pre- and post-natal period, where mental disorders affect 20-40% of women, with implications extending to their children. Additionally, 14% of adolescents in South Africa live with mental health issues, compared to 25.7% of the general population. Those with other communicable and non-communicable diseases, like HIV patients (40% experience depression symptoms)[6] and diabetics (two out of three develop depression), are more prone to mental health challenges. Moreover, disabled individuals facing stigma and exclusion, as well as those with a family history of mental health issues, adverse childhood events, and social isolation, are at an increased risk. The COVID-19 pandemic exacerbated these issues by intensifying social isolation, job losses, and poverty, underscoring the intricate interplay between socioeconomic factors and mental health.

Limited updated data available on prevalence underscores the critical gaps in understanding the extent of mental disorders in South Africa. This scarcity highlights the urgent need for comprehensive research to understand the burden of disease across all mental health challenges experienced within the nation.

Mental health service provision is hindered by resource disparities, infrastructure challenges, and implementation gaps, affecting access and quality of care nationwide.

The DHIS data from 2017 to 2023 illuminates a concerning trend in mental health care seeking behavior across South African provinces, with some regions experiencing declines despite an overall increase in outpatient care utilisation. This highlights the need for targeted interventions, particularly in provinces like Mpumalanga and Northern Cape where patient utilisation appears to be fluctuating.

The national public health system in South Africa is structured into primary, secondary, and tertiary levels of care, with each mandated to provide mental health services corresponding to their level of care. However, resource constraints, including limited budget allocation and uneven distribution of resources across provinces,

significantly impact service delivery and quality. This next section delves into the challenges faced in service provisioning and highlights opportunities for improvement.

RESOURCE ALLOCATION AND DISPARITIES The allocation of resources for mental health services in South Africa is disproportionately low, with only 5% of the national healthcare budget dedicated to this critical area. This limited allocation has resulted in inadequate infrastructure, staffing, and service quality across the country. Disparities in resource allocation are particularly evident when comparing provinces, with some, like the Western Cape, allocating a higher percentage of their healthcare budget (8%) to mental health, while others, like Mpumalanga, allocate as little as 2%. These discrepancies in resource allocation contribute to significant variations in the accessibility and quality of mental health services across provinces. Provinces such as KwaZulu-Natal and the Western Cape have more human and financial resources available, allowing them to develop and equip facilities with necessary staff and equipment, ultimately influencing the standard of healthcare delivery. According to data from the District Health Information System (DHIS) and rates of probable depression across provinces from the Wits (2019) study, there is a great degree of variability in provinces' access to human and financial resources, and how this relates to their population to be serviced. National Treasury gives funding resources to Provincial Treasury to share with provinces. This is based on equitable share, which considers the population numbers per province and other measures. Provinces such as the Eastern Cape, Mpumalanga, and Gauteng must service a greater population of mental health patients per facility when compared to provinces like KwaZulu-Natal and the Free State. The variability in provincial resources means that some provinces require additional support to deliver services appropriately or that the national treasury needs to redefine the factors used in determination of provincial health budgets.

INFRASTRUCTURE AND STAFFING CHALLENGES Infrastructure inadequacies and staff shortages are pervasive challenges in South Africa's mental health service delivery. One should also keep in mind that the proportion of nurses to primary healthcare clients has grown over time as there has been a rise in the number of registered nurses in eight out of nine provinces in the past five years. Despite efforts to improve infrastructure and recruit additional staff, persistent challenges such as poor referral systems, stockouts of essential medications, and insufficient training of healthcare professionals hinder effective service delivery. The implementation of initiatives like the Ideal Clinic guidelines, aimed at standardising care, has been hindered by operational gaps and resource constraints, further impacting the quality of mental health services. In 2019, 83% of all primary healthcare facilities in South Africa met the Ideal Clinic guidelines, indicating progress in standardising care delivery. However, challenges such as infrastructure inadequacies and staffing shortages continue to hinder the full implementation of these guidelines. One strategy to address staff shortages is task-sharing, which involves delegating certain mental health tasks to lower-skilled healthcare workers. While task-sharing can help alleviate staff shortages, it is limited by low skill levels and stigma around providing mental health services.

POLICY IMPLEMENTATION AND TREATMENT GAP While national policies exist to address the mental health crisis, the degree of implementation varies across provinces, highlighting the need for more consistent

enforcement and monitoring mechanisms. Opportunities for public-private partnerships could enhance access to mental health services, particularly in underserved areas. Despite these efforts, estimates suggest that only a quarter of individuals in need of mental healthcare receive it, indicating a substantial treatment gap. This gap not only exacerbates the burden of mental illness on individuals and families but also imposes significant societal costs in terms of lost productivity and reduced quality of life. Despite national efforts to address this crisis, significant implementation gaps remain. South Africa loses billions due to mental health issues impacting productivity. Integrating mental health into primary healthcare services and task-sharing approaches have been introduced to address staff shortages, but they are limited by low skill levels and stigma. Government has promoted the development of key structures in policies such as a mental health directorate, a district health specialist team, and provincial mental health service delivery plans with appropriate budgets.

South Africa's mental health policy has undergone a dynamic evolution, transitioning from fragmentation to integration, in its quest to address pressing mental health needs.

South Africa's journey towards developing a comprehensive mental health policy has undergone significant milestones and evolution over time, reflecting the country's commitment to addressing mental health challenges within the healthcare system.

EVOLUTION OF MENTAL HEALTH POLICY IN SOUTH AFRICA The evolution of mental health policy in South Africa reflects a journey towards greater recognition and prioritisation of mental health within the country's healthcare system. Beginning with the introduction of the Mental Health Policy Guidelines in 1997, the government took its initial steps towards formalising mental health policy, albeit facing challenges related to adoption protocols and dissemination. The enactment of the Mental Health Care Act in 2002 marked a significant milestone, emphasising the protection of individuals' rights and the standardisation of mental health services across provinces. However, challenges persisted, leading to the establishment of the National Mental Health Policy Framework and Strategic Plan in 2013, aimed at providing practical guidance for policy implementation. The most recent iteration, the National Mental Health Policy Framework and Strategic Plan (2023-2030), builds upon previous efforts, focusing on enhancing access to care, improving service quality, and addressing social determinants of mental health. With clear mechanisms for monitoring progress and data-driven decision-making, this plan represents a continued commitment to strengthening mental health services and support systems across South Africa.

COMPARISON WITH WHO STANDARDS While South Africa's mental health policies have evolved over time and are aligned with WHO standards, implementation has often lagged. Comparisons with WHO standards highlight areas where South Africa's policies excel and where improvements are needed to meet international best practices. This ongoing evaluation and alignment with global standards are essential for ensuring that South Africa's mental health policies remain effective and responsive to the needs of its population.

CHALLENGES IN POLICY IMPLEMENTATION Despite the introduction of comprehensive policy frameworks, South Africa continues to face significant challenges in the implementation of mental health policies. One such challenge is the inadequate coverage of mental health indicators in existing data collection systems, such as the District Health Information System, which hinders effective monitoring and management of mental health services. Moreover, barriers to effective policy implementation include poor dissemination of policies and guidelines, insufficient political support and funding, a lack of collaboration across government sectors, limited pilot projects to demonstrate impact, and inadequate stakeholder engagement.

ESTABLISHING A ROBUST SYSTEM for tracking and monitoring health program performance is fundamental for effective healthcare management. This requires the availability of high-quality, reliable, and timely data. In South Africa, several surveys and routine surveillance systems serve as vital sources of data for non-communicable diseases (NCDs) and mental health.

SURVEYS PROVIDING DATA ON NCDS AND MENTAL HEALTH One of the primary sources of data on health indicators, including NCDs and mental health, is the South Africa Demographic and Health Surveys (SADHS). Conducted periodically by the South African Medical Research Council (SAMRC) and the National Department of Health (NDoH), SADHS collects comprehensive data on health, nutrition, and demographic indicators. According to SAMRC, the 2020 SADHS revealed that approximately 17.5% of South Africans aged 16 and older reported experiencing a common mental disorder. Similarly, the South African National Health and Nutrition Examination Survey (SANHANES) is another critical survey providing data on health and nutrition-related factors. The South African Stress and Health (SASH) Survey also gathered crucial data on health behaviours, chronic diseases, and nutritional status. This study included modules specifically focused on mental health, providing valuable insights into the prevalence and patterns of mental health conditions in South Africa. The survey found that 9.7% of South Africans aged 15 years and older experienced a depressive disorder in the past 12 months. These surveys are however once-off and do not provide up to date information for decision-making.

ROUTINE SURVEILLANCE SYSTEMS In addition to surveys, routine surveillance systems play a pivotal role in collecting data on health indicators, including mental health variables. The District Health Information System (DHIS), managed by the National Department of Health, serves as the primary routine surveillance system in South Africa. DHIS collects information on various health indicators, including mental health caseloads, attempted suicide rates, and treatment rates. According to the various sources of mental health data as discussed in Theme 4, mental health caseloads varied across different provinces, with higher caseloads reported in urban areas compared to rural regions. The data also highlighted disparities in access to mental health services, with certain demographic groups facing greater barriers to care. Additionally, these data sources showed variations in treatment rates for mental health conditions, emphasising the need for targeted interventions to address gaps in service provisioning.

CHALLENGES IN DATA COLLECTION AND QUALITY Despite the availability of data from surveys and routine surveillance systems, several challenges persist in ensuring data quality and reliability. One major challenge is the quality of DHIS data. Since data collection is primarily the responsibility of individual healthcare facilities, inconsistencies and inaccuracies often arise, impacting the reliability of the data. Moreover, DHIS data is aggregated at the facility level, limiting the ability to conduct detailed patient-level analysis. This hinders efforts to understand individual healthcare needs and outcomes accurately. Additionally, DHIS data lacks essential socio-demographic information about patients, hindering efforts to assess healthcare disparities and tailor interventions accordingly. Provinces are also reluctant in collecting provincial specific information that responds to unique provincial needs and challenges through the provincial indicator data sets (PIDS) and only collect what has been determined at national indicator dataset level (NIDS). There is an opportunity for data collected at the PIDS and even DIDS (district indicator data set) level to obtain insights into more critical indicators required for efficient service delivery planning at a provincial level. According to a report by the National Department of Health, staff at the facility level may also lack adequate training and skills for data collection and analysis, further compromising data quality and reliability. Without standardised data collection processes and comprehensive training programs, the accuracy and completeness of the data remain a significant challenge.

CONCLUSION Addressing the escalating mental health crisis in South Africa demands a multi-faceted approach that acknowledges both the prevailing risk factors and the disparities in resource allocation across provinces. While provinces like Gauteng, Western Cape, and KwaZulu-Natal boast sufficient resources, others such as the Northwest, Northern Cape, and Mpumalanga are notably disadvantaged. Collaborative efforts between national and provincial health departments as well as national treasury are essential to redistribute and optimise existing resources effectively, ensuring that evidence-based interventions are implemented and monitored. Moreover, policy implementation must be bolstered by adequate human, financial, and technical support to bridge the gap between policy intent and execution. However, the challenge is hindered by the scarcity of reliable data, as well as comprehensive data collection at provincial level, highlighting the urgent need for comprehensive, standardised data collection mechanisms to inform decision-making and

💡 **INSIGHTS**

- RSA prevalence rates are increasing.
- Covid19 pandemic context is a significant risk factor.
- Vulnerable population groups are most at risk.
- Considering geographical (provincial) variances is critical.
- Burden of disease insights must be viewed in context of available resources.
- RSA mental health policies are aligned with International best practices.
- RSA needs better data to enable evidence-based decision making to lower prevalence rates over time.

improve mental health interventions across South Africa. To effectively address the mental health crisis, it is imperative to establish systematic data collection mechanisms to inform policy and resource allocation, adjust budgets based on disease burden, enforce adherence to national healthcare standards, and integrate mental health services into primary healthcare settings to enhance accessibility and outreach throughout the country.

CONTENTS

1. INTRODUCTION

THIS SECTION PROVIDES AN INTRODUCTION TO THE PROJECT AND WHY IT WAS INITIATED

The South African National Development Plan (NDP) has listed poverty, inequality and unemployment as critical challenges undermining the development of South Africa. In response, the National Planning Commission (NPC) has been tasked with the mandate to promote and advance the execution of the NDP, to alleviate these three societal concerns (National Planning Commission, 2019)

[1]. In tracking progress towards this goal, the NPC conducted a review of the NDP in 2020. This review highlighted some gaps, among which was the inadequate emphasis placed on mental health within Chapter 10 (Health related chapter) of the NDP.

Given the pressing challenges and acknowledging the interconnectedness of mental health with broader health and societal concerns, the NPC has recommended an expansion of mental health services in South Africa guided by the principle of universal access to healthcare. To better understand the mental health landscape, Deloitte was contracted by the Department of Planning, Monitoring and Evaluation (DPME) on behalf of the NPC, to undertake a situational analysis of mental health in South Africa. This project will serve as a foundational step toward developing evidence-based strategies to address the mental health crisis in South Africa.

The primary objective of this project was to understand "The burden and preparedness of South Africa to address the mental health challenge". This situational analysis report presents findings on the prevalence and incidence of mental disorders, along with associated risk and protective factors. It sets out the providers of mental health services and through which platforms and facilities these services are provided. The report also outlines the evolution of mental health policy over time and the challenges encountered in its implementation. Finally, the report highlights available data on mental health care, essential for monitoring and evaluating progress towards policy objectives, ensuring quality service provisioning, and reducing incidence rates.

The report is split into 10 sections which is described below. All additional information relevant to the report will be included in the Appendices.

1. Introduction
2. Background
3. Aims and Objectives
4. Scope of work
5. Approach to execute on situational analysis
6. Methodology for the situational analysis
7. Findings
8. Discussion
9. Study Limitations
10. Conclusion

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[1] National Planning Commission. (2019). *A review of the National Development Plan, 2030.* South Africa: National Planning Commission. Available at: https://www.nationalplanningcommission.org.za/assets/Documents/NDP%20REVIEW.pdf

2. BACKGROUND

THIS SECTION INCLUDES AN OVERVIEW OF THE STATE OF MENTAL HEALTH IN SOUTH AFRICA AND THE FACTORS INFLUENCING IT

The Global Burden of diseases estimated that in 2016, 15.9% of South Africans suffered from a mental health issue. Anxiety, depression, and substance-abuse disorders contributed the most as single disorders (National Mental Health Policy Framework and Strategic Plan 2023 – 2030, 2023)[2]. Additionally, the amount of people experiencing depressive symptoms and the people at-risk of developing a mental health issue at some point in their lives was 30% in 2019 which demonstrates an increased risk of South African's developing mental health issues over time.

In addition to the increasing burden of mental disorders mental health issues are also correlated to the existing quadruple burden of disease in South Africa. The quadruple burden of disease is caused by communicable diseases such HIV/AIDS and TB, as well as several non-communicable diseases such as diabetes and cardiovascular disease (Global Health Observatory, 2017)[3]. Furthermore, over 40% of people living with HIV in South Africa have a diagnosable mental disorder (The South African College of Applied Psychology, 2019)[4].

Patients struggling to overcome these communicable and non-communicable diseases are further impacted by the interaction between health and other socio-economic factors such as income levels, life stage (i.e., children and adolescents), whether someone has children as well as an individual's gender. Literature on the social determinants of health shows that there is a strong relationship between the population's health and their ability to work and earn an income. Sick individuals are more likely to lose income through both the direct and indirect costs associated with their illness. This cycle between poverty and illnesses has been exacerbated by the impact of Covid-19 (Garman, 2020)[5]. One study across 2020 to 2021 found that individuals who lost their job as a direct result of Covid-19 were significantly more likely to show depressive symptoms. Overall, the proportion of South African individuals that screened positive on the Depression Indicator increased as the lockdown stages became stricter (Garman, 2020)[5]. Other risk factors such as stigma, experiencing early life adversities and experiencing stressful life events (such as contracting a life-threatening illness) were also found to significantly increase the chances that an individual will experience a mental health issue (Craig et. al, 2022 and Seedat at. al, 2009)[6,7]. Stigma is especially relevant in South Africa where cultures consider the presence of mental health issues taboo and engender the characteristic of shame. As a result of stigma many individuals fail

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[2] National Department of Health. (2023). National Mental Health Policy Framework and Strategic Plan 2023 – 2030. South Africa: National Department of Health. Available at: https://www.spotlightnsp.co.za/wp-content/uploads/2023/04/NMHP-FINAL-APPROVED-ON-30.04.2023.pdf
[3] Global Health Observatory. (2017). Country Cooperation Strategy (South Africa). Available at: ccsbrief_zaf_en.pdf
[4] The South African College of Applied Psychology. (2019). 'The Shocking State of Mental Health In South Africa', 21 August 2019. Available at: (sacap.edu.za)
[5] Garman, E. (2020). 'The vicious cycle of mental health and poverty'., UCT News, 9 July. Available at: https://www.news.uct.ac.za/article/-2020-07-09-the-vicious-cycle-of-mental-health-and-poverty
[6] Craig A, Rochat T, Naicker SN, Mapanga W, Mtintsilana A, Dlamini SN, Ware LJ, Du Toit J, Draper CE, Richter L and Norris SA (2022) The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa. Front. Public Health 10:986531. doi: 10.3389/fpubh.2022.986531.
[7] Seedat S, Stein DJ, Jackson PB, Heeringa SG, Williams DR, Myer L. Life stress and mental disorders in the South African stress and health study. S Afr Med J. 2009 May;99(5 Pt 2):375-82. PMID: 19588801; PMCID: PMC3203647.

to understand their condition, seek the care they need and receive support (Egbe et. al, 2014 and Alemu et. al, 2023)[8,9].

While the burden of disease has increased over time, the supply for mental health support and services remains limited and inequitably distributed. According to MASIVIWE[10], a project initiated by U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Foundation of Professional Development (FPD) there are 394 mental health facilities across South Africa including specialised hospitals, care homes and community-based centres. However, the distribution of these facilities is inequitable with majority of these facilities established in the densely populated province of Gauteng. While there have been efforts to increase the integration of mental health services into primary healthcare, as suggested by the policy on integration of mental health care into PHC in South Africa, the White Paper for the Transformation of the Health Systems in South Africa (1997), Guidelines for the management of Mental disorders and the National Mental Health Policy Framework and Strategic Plan (2013-2020 and 2023-2030) there are still implementation challenges which exist in ensuring all Primary Health Care facilities provide mental health services (Hlongwa & Sibiya, 2019)[11]. Currently there are 3472 primary healthcare (PHC) clinics in South Africa which provide the first point of contact for individuals seeking mental health support[12]. However, according to Seedat et. al (2009), only three out of nine provinces in South Africa indicate that mental health services can in fact be accessed through PHC facilities and clinics, with the other six provinces wearier of making this statement due to implementation challenges which still exist[7]. The National Department of Health feedback indicates that all primary healthcare clinics nationwide offer some level of mental health services based on available resources and skills. This includes referring individuals needing specialised care, treatment, and rehabilitation to higher-level facilities[13]. As a result, these limitations in service delivery may be due to insufficient resources and competencies at certain facilities. Besides PHC facilities, service provisioning for mental health care in South Africa continues to be disparate across the healthcare system with some provinces having no specialised psychiatric hospitals and others having as many as five.

In terms of availability of staff, South Africa currently only has 930 psychiatrists, which illustrates a ratio of less than 2 professionals per 100,000 people (WHO,2020)[14]. The situation is more dire when looking at child and adolescent services, where there is less than one (0.11) psychiatrist available for child based mental healthcare services and a total of 143 mental healthcare workers in this space[14]. This is concerning given adolescents are more predisposed than other age groups to experiencing mental health issues (Pillay,2022)[15].

[8] Egbe, C.O., Brooke-Sumner, C., Kathree, T. et al. Psychiatric stigma and discrimination in South Africa: perspectives from key stakeholders. BMC (BIOMEDCENTRAL) Psychiatry 14, 191 (2014). https://doi.org/10.1186/1471-244X-14-191.
[9] Alemu, W.G., Due, C., Muir-Cochrane, E. et al. Internalised stigma among people with mental illness in Africa, pooled effect estimates and subgroup analysis on each domain: systematic review and meta-analysis. BMC (BIOMEDCENTRAL) Psychiatry 23, 480 (2023). https://doi.org/10.1186/s12888-023-04950-2.
[10] MASISWE Maps. (n.d). Available at: Masiwiwe Map
[11] Hlongwa EN, Sibiya MN. Challenges affecting the implementation of the Policy on Integration of Mental Health Care into primary healthcare in KwaZulu-Natal province. Curationis. 2019 Aug 21;42(1): e1-e9. doi: 10.4102/curationis. v42i1.1847. PMID: 31478729; PMCID: PMC6739558.
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[13] Stakeholder Interview, 2024
[14] WHO. (2020). Mental Health Atlas 2020 South Africa. Available at: https://www.who.int/publications/m/item/mental-health-atlas-2020-country-profile--south-africa
[15] Pillay J. Difficulties experienced by South African adolescents during COVID-19 lockdown: implications for early mental health interventions. South African Journal of Psychology. 2023 Jun;53(2):211–24. doi: 10.1177/00812463221133964. Epub 2022 Nov 11. PMCID: PMC9659695.

Mental disorders are the number one leading burden of disease in children and adolescents affecting 10–20% of children and adolescents around the world (Mokitimi et. al, 2014)[16]. Considering 38% of South Africa's population are children and adolescents there is a need to focus on mental health care for this group. While there is a national policy focused on child and adolescent mental health (CAMH) none of the South African provinces has a CAMH policy or implementation plan based on this national policy showing the lack of focus on this important group[16].

The availability of resources, both facilities offering mental health services and adequately skilled staff is enabled by the amount of funding allocated to mental health services from the healthcare budget. Nationally, only 5% of the healthcare budget is allocated to mental health with provinces apportioned its equitable share predominantly based on their population size. Provinces have discretion in determining the allocation of their total budget to healthcare services based on their deep understanding of population need and context. Provinces are then responsible for costing different healthcare services according to need and determining how much of their total budget to allocate towards mental health care (Docrat et. al, 2019)[17].

South Africa has taken critical steps forward to strengthen its mental health system including reforming the Mental Health Care Act 17 of 2002 (MHCA). The development of the South African National Mental Health Policy Framework and Strategic Plan 2013–2020 (MHPF) and the adoption of the National Health Insurance (NHI) Policy (2017) to promote equity in health service delivery towards universal healthcare (UHC). However, implementing mental health policies within countries that have decentralised health systems and constrained budgets is challenging. As a result, it is estimated that only a quarter of individuals in need of mental health care receive the necessary care, leaving most of the population undiagnosed and untreated (Wits University, 2022).[18]

While greater efforts are needed for the prevention and treatment of mental health illnesses, the availability of comprehensive data to understand the current prevalence of mental, neurological and substance use (MNS) disorders and asses the accessibility of these services is limited (National Mental Health Policy Framework and Strategic Plan 2023 – 2030, 2023).[2] By improving data availability and analysis, policymakers and healthcare providers can gain a better understanding of the prevalence of mental disorders, identify underserved populations, and design targeted interventions to improve access to mental healthcare services.

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[16] Mokitimi S, Jonas K, Schneider M, de Vries PJ. Child and Adolescent Mental Health Services in South Africa-Senior Stakeholder Perceptions of Strengths, Weaknesses, Opportunities, and Threats in the Western Cape Province. Front Psychiatry. 2019 Nov 26; 10:841. doi: 10.3389/fpsyt.2019.00841. PMID: 31849722; PMCID: PMC6901972.

[17] Sumaiyah Docrat, Crick Lund, & Donela Besada. (2019). An Evaluation of the Health System Costs of Mental Health Services and Programmes in South Africa. University of Cape Town. Available at: https://doi.org/10.25375/UCT.9929141

[18] Wits University. (2022). 'Mental health in SA is at shocking levels but people are not seeking help', Wits University, 14 November. Available at: https://www.wits.ac.za/news/latest-news/research-news/2022/2022-11/mental-health-in-sa-is-at-shocking-levels-but-people-are-not-seeking-help-.html#:~:text=2022%2D11-,Mental%20health%20in%20SA%20is%20at%20shocking,people%20are%20not%20seeking%20help&text=A%20new%20study%20reveals%20that,Complex%20factors%20are%20contributors.

3. AIMS & OBJECTIVES

THIS SECTION INCLUDES AN OVERVIEW OF THE AIMS AND OBJECTIVES OF THIS SITUATIONAL ANALYSIS

The aim of the project is to undertake a detailed Situational Analysis of Mental Health in South Africa, prompted by the 2020 NDP Review Report, highlighting insufficient attention given to mental health. This analysis aligns with the principles of **universal health access**, **target 3.4 of the Sustainable Development Goals as well as relevant national policies and framework.**

The following project objectives were defined and agreed upon during the inception phase of the project.

1. Conduct a detailed mental health **prevalence landscape** to comprehend the current need for mental healthcare servicing in South Africa

2. Conduct a decomposition analysis to clarify the links between **poverty** and mental health as well as the **relationship between mental health and other socio-economic determinants**, such as age (with a focus on children and adolescents), gender, the presence of other communicable and non-communicable diseases and being a mother. Analyse the impact of the **Covid-19** pandemic and other risk factors such as stigma and stressful life events on the prevalence rates of mental illness.

3. Provide an overview of available **mental health services** across **different types** of **public and private providers** such as **government (across all healthcare levels from primary to tertiary care)**, **non-governmental organisations** (NGOs) and **community-based organisations** (CBOs). Analyse funding distribution and assess geographical accessibility, including provincial and urban-rural divides. Evaluate the integration of mental health services within primary healthcare settings, highlighting challenges and successes encountered. Develop 2-3 case studies to contextualise what **opportunities exist for public and private collaborations** in the mental healthcare space as well as a **case study on the Life Esidimeni** tragedy.

4. Analyse the evolution of **policy**, **legislative** and **regulatory frameworks** between 1994 and 2023, assessing their impact on access to mental healthcare services.

5. Conduct a comprehensive analysis of **mental health services data, focussing on** the District Health Information System (DHIS) in South Africa using desktop research and primary data collection through stakeholder interviews to understand **what measures are available and how this data is collected and managed** to track progress to goals outlined in the NDP.

4. SCOPE OF WORK

THIS SECTION INCLUDES A SUMMARY OF THE LEVEL OF DETAIL CONSIDERED TO BE WITHIN SCOPE FOR THIS PROJECT AS AGREED UPON IN THE INCEPTION PHASE OF THE PROJECT

The below table outlines the project scope pertaining to the research, findings and insights generated from this project. An important caveat is that this report made use of publicly available information and where possible requested access to additional datasets and reports housed by the South African government. The overall analysis will provide information at a provincial level with an urban/ rural lens.

Table 1: Scope of Work

| RESEARCH THEME	IN-SCOPE
Types of mental disorders	The assessment of the prevalence of mental illness will be limited to (Subject to data availability): • Anxiety disorders, including anxiety, obsessive compulsive disorder, phobias, panic disorder, post-traumatic stress disorder and postpartum related maternal health disorders. • Mood disorders, including depression and bipolar disorders. • Substance-use related disorders including alcohol and drug abuse disorders. The following disorders will be assessed based on data availability: • Eating disorders including anorexia nervosa and bulimia nervosa. • Psychotic disorders such as schizophrenia. • Personality disorders such as borderline personality disorder and narcissistic personality disorder. This prioritisation is based on data availability constraints, time constraints and use of the 80/20 principle with depression, anxiety, and substance-abuse making up the bulk of population incidence for mental illness and research investments. All information on prevalence and incidence will be disaggregated by age and other related socio-economic variables where data allows for this.
Suppliers of mental health services	Service coverage of public and private providers across government (including primary, secondary, and tertiary care), NGO and CBO based service delivery mechanisms will be reviewed. An aggregated overview of their service coverage across geography (i.e., an urban/rural lens) will be provided, along with an analysis of the human and financial resources allocated to the service at an aggregated level. To assess the impact of integrating mental health into primary health care an overview for each provinces' progress towards the integration of mental health services into the primary healthcare system and the general implementation challenges and successes will be provided. One case study will be undertaken on Life Esidimeni to outline lessons learnt, while 2-3 case studies on examples of public-private partnerships in the mental health space will be conducted to contextualise available opportunities.
Policy, regulation & legislative analysis	Existing policies, regulation and legislation formulated and implemented between 1994 and 2023 will be reviewed.

RESEARCH THEME	IN-SCOPE
Data availability	Publicly available data will be collected and assessed, and collaboration with NPC and DPME will be sought to facilitate introductions to pertinent DHIS stakeholders and secure access to any information or documentation to address potential gaps. When assessing available data, a comparison will be made to what is currently advised to be collected in the National Mental Health Policy Framework and Strategic Plan 2023-2030, as well as what is recommended in WHO international best practice guidelines.

5. APPROACH TO EXECUTE ON THE SITUATIONAL ANALYSIS

THIS SECTION INCLUDES AN EXPLANATION OF APPROACH TAKEN TO CONDUCT THE SITUATIONAL ANALYSIS OF MENTAL HEALTHCARE IN SOUTH AFRICA

The planned approach for this project was collaborative, involving close coordination with the NPC and DPME teams to ensure timely delivery of the project outcomes within the agreed framework. The project unfolded across three phases: (1) Inception Phase, (2) Immersion and Research Phase, and (3) Develop and Present Phase, as shown in Figure 1 below.

Figure 1: Project Phases
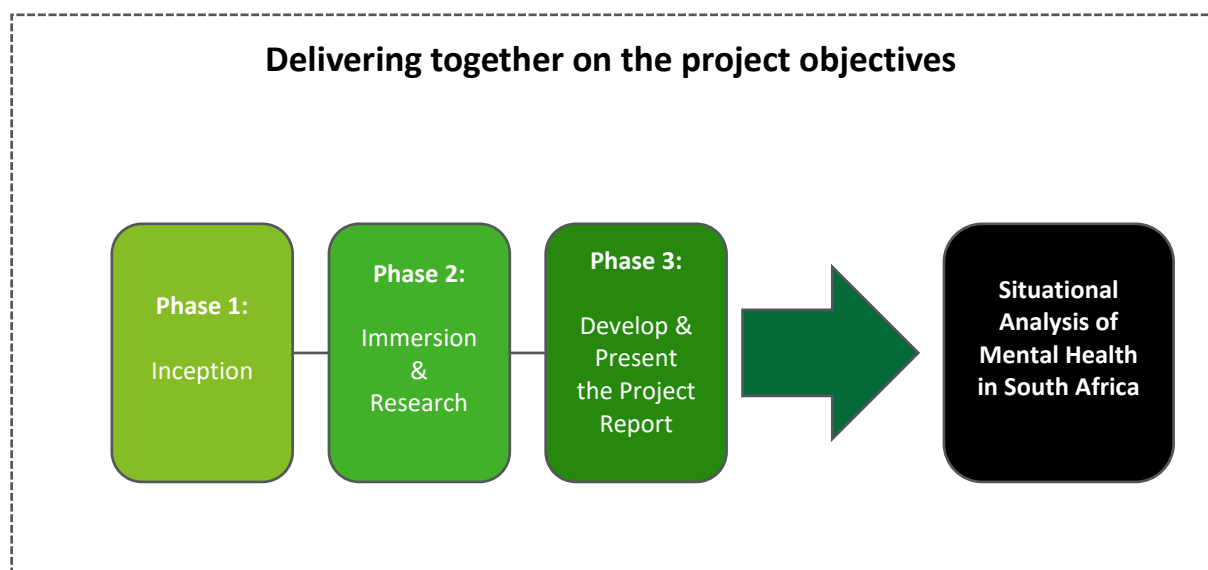
The Inception Phase commenced with a stakeholder meeting to align on project governance, methodologies, timelines, and deliverables. Subsequently, an inception report was developed and presented, incorporating feedback to ensure alignment and clarity on objectives.

Transitioning to the Immersion and Research phase, a comprehensive investigation blended secondary research and primary data gathering. Secondary research entailed an exhaustive review of literature, policy documents, and statistical data, laying the groundwork for understanding the mental health landscape. Concurrently, primary research involved stakeholder interviews, engaging both internal subject matter experts and external stakeholders. These interviews facilitated insights, validation of findings, and an understanding of the mental health landscape, encompassing government and public health officials.   A critical aspect of this phase was formulating an analytical framework to structure and organise the collected information, addressing key themes such as disease burden, service provisioning, policy development and data availability, facilitating a systematic analysis.

The Develop and Present phase represents the final stage of the project, focusing on refining and presenting findings. This draft situational analysis report serves as a foundational document, subject to review and refinement through stakeholder feedback. Subsequently, the final report will be produced, accompanied by a PowerPoint presentation, executive summary and a policy brief. This phase ensures effective communication of key insights and findings to stakeholders, empowering informed decision-making and strategic planning.

6. METHODOLOGY FOR THE SITUATIONAL ANALYSIS

The methodology employed for conducting the situational analysis involved a systematic mixed-methods approach integrating both primary and secondary qualitative and quantitative data collection across four key thematic areas. These thematic areas included: (1) understanding prevalence and incidence of mental and neurological disorders in South Africa ; (2) understanding the service providers of mental health care in the public sector across government, NGO and CBO facilities as well as their service delivery packages and mechanisms of delivery; (3) reporting on mental health policy changes between 1994 and 2023 and their implementation across provinces; and finally (4) reporting on the availability and quality of mental health data in South Africa.

First, an analytical framework was developed to guide the research process, outlining specific indicators and sub-indicators within each theme. This framework explained the relevance of each sub-indicator in addressing the overarching research question and provided clarity on the measurement metrics used to assess them.

For each theme, a combination of primary and secondary data collection was utilised. Secondary data collection involved an extensive literature review from reputable journals and online databases, such as Taylor & Francis Online, The Lancet and Nature Medicine, among others. Specific search terms tailored to South Africa's context were used to gather relevant information related to each theme. In addition to the literature review, efforts were made to access pertinent datasets, such as the District Health Information System and Master Health Facility List, to supplement insights obtained from secondary data collection.

Primary data collection included stakeholder interviews with key experts and representatives from relevant organisations. Stakeholders interviewed encompassed a range of perspectives, including academic, researchers, government officials, healthcare practitioners, and representatives from non-governmental organisations and community-based organisations involved in mental health service provision.

The selection of interviewees and data sources was guided by considerations such as geographical representations, expertise, and relevance to the specific theme under investigations. For instance, efforts were made to engage with provincial leads for mental health in a diverse sample of provinces to ensure a comprehensive understanding of service provision across different regions. There were difficulties in interviewing the provincial managers for the mental health programme, and only one of them was interviewed for this project. However, other mental health stakeholders were contacted and provinces such as the Northern Cape and Gauteng were involved.

In addition to data collection, robust analysis methods were employed to systematically analyse both qualitative and quantitative information gathered during the situational analysis.

Qualitative analysis:

The qualitative data gathered from sources such as journals, reports, and articles were analysed through an inductive approach. This involved identifying key themes and insights that emerged from the data. Key concepts and patterns were then organised to provide a comprehensive understanding of the qualitative information. Additionally, stakeholder interviews also contributed qualitative data. Transcripts of these interviews were systematically reviewed, and recurring themes and patterns were identified and coded. Finally, these themes were synthesised to draw out key insights that were relevant to each thematic area.

Quantitative analysis:

Quantitative data extracted from secondary sources were organised and analysed using descriptive statistics. Data were inputted into Excel spreadsheets, and relevant descriptive analyses such as frequency distributions and cross-tabulations were conducted. This allowed for a deeper understanding of variables such as prevalence, incidence, provider distribution, and funding allocation across different contexts. Similarly, quantitative data obtained from stakeholder interviews were subjected to similar qualitative analysis methodologies. This ensured consistency and allowed for meaningful comparisons between different data sources.

Synthesis:

After analysing qualitative and quantitative data separately, both sets of information were combined to provide a complete understanding of the mental health situation in South Africa. The key findings from both types of analyses were integrated to generate comprehensive insights. The research methodology used was thorough and rigorous, providing a meticulous understanding of the mental health landscape in the country. The insights gained from this research can be used to inform strategic decision-making and interventions in policy and service provisioning.

7. FINDINGS

THEME 1 UNDERSTANDING THE BURDEN OF DISEASE & FACTORS INFLUENCING THIS BURDEN

OBJECTIVES FOR THEME 1:

Conduct a detailed mental health prevalence landscape to comprehend the current need for mental healthcare servicing in South Africa

Conduct a decomposition analysis to clarify the links between poverty and mental health as well as the relationship between mental health and other socio-economic determinants, such as age (with a focus on children and adolescents), gender, the presence of other communicable and non-communicable diseases and being a mother. Analyse the impact of the Covid-19 pandemic and other risk factors such as stigma and stressful life events on the prevalence rates of mental illness.

The information presented in this theme will comprise a literature review of available incidence and prevalence studies reporting results for South Africa, except for two national surveys: the U-Report 2023 and Ipsos Global Health Services Monitor 2023. The literature review will also cover information from studies on the links between poverty and mental health and other socio-economic determinants. Additionally, stakeholder interview insights were also used in this section.

Understanding the occurrence and impact of mental illness within a population requires fundamental epidemiological metrics such as incidence and prevalence. Incidence measures the rate of new cases emerging over time, while prevalence reflects the total number of existing cases at a specific moment, as illustrated in Figure 2 (Rothman, Greenland and Lash, 2008)[19]. These metrics provide vital insights into the burden of mental disorders, guiding the development of targeted interventions and resource allocation strategies to address both prevalent conditions and the risk of new cases.

Figure 2: Depiction of Incidence and Prevalence[17]
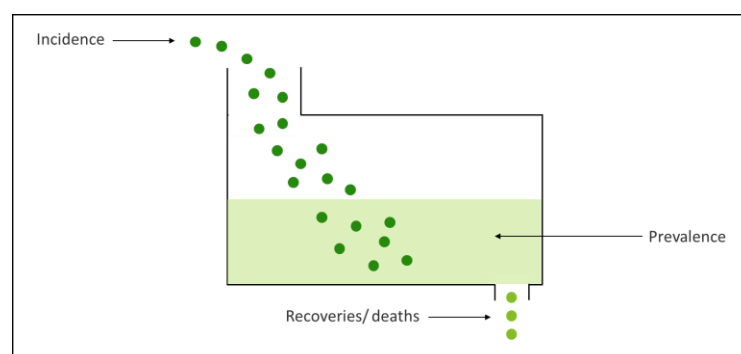
The burden of mental disorders is increasing, with a 13% increase in mental health conditions and substance use disorders over the decade leading up to 2017 (WHO, 2021)[20]. Approximately 14% of the world's children and

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[19] Rothman, K.J., Greenland, S. and Lash, T. (2008) Modern epidemiology. Third Edition. Lippincott Williams & Wilkins, Philadelphia, 303-327.
[20] WHO. (2021). 'Mental health of adolescents'. Available at: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

adolescents experience mental health conditions, with suicide ranking as the fourth leading cause of death among 15-to 19-year-olds[20].

Poorly managed mental health conditions significantly impact various aspects of life, such as school and work performance, relationships with family and friends and the ability to participate in social gatherings. From a global perspective it is estimated that 1 in 3 women and 1 in 5 men will experience major depression during their lifetimes (Saloni et. al, 2023)[21]. Depression and anxiety stand out as prevalent conditions among mental disorders, while schizophrenia and bipolar disorder although less common have an equally significant impact on people's lives[21]. Despite the treatability of these disorders, studies such as Knaak, Mantler, Szeto (2017)[22] and Wainberg et. al (2017)[23] reported challenges in accessing quality care and societal stigma contribute to a substantial number of untreated individuals with mental health issues.

In developed countries, approximately 50% of individuals with depression go undiagnosed or untreated, a number that skyrockets to 80% in under-developed countries (WHO, 2004)[18]. The South African Health and Stress Study conducted between 2003-2004 surveyed 4 351 South Africans using Diagnostic Assessment of Lifetime and 12-month Diagnostic and Statistical Manual (DSM)-IV to measure mental disorders. Results showed that 15.8% of the population will experience an anxiety disorder while 9.8% will encounter mood disorders over their lifetime (Herman et. al, 2009)[22]. The 12-month prevalence estimate showed that 16.5% of the sampled population had a mental health issue, with anxiety (8.1%) being the most common.

According to the Global Burden of disease assessment in 2016, mental health issues affected 15.9% of South Africans. Anxiety, depression, and substance-use disorders were the most prevalent single disorders while other mental disorders such as bipolar and schizophrenia reported lower rates of prevalence (Docrat et. al,2019)[15]. In 2019 the World Health Organization estimated that about 12.5% of people worldwide live with a mental disorder[24]. South Africa's reported rates of 16.5% (12-month prevalence) and 20% (lifetime prevalence) are higher than the global prevalence percentage, underscoring the heightened vulnerability of South Africans to mental health challenges (Herman et. al, 2009)[25].

A more recent survey conducted by Ipsos Global (2023)[26] agree with the severity experienced in South Africa with higher proportions of South Africans expressing that feeling stressed has negatively impacted their day-to-day functioning when compared to global rates. Figure 3 below shows that 69% of South Africans felt that stress impacted their daily life compared to 62% of people globally. Stress is also seen to impact on the individual's ability to go to work with 50% of South Africans saying they could not go to work for a period because of stress,

[21] Saloni Dattani, Lucas Rodés-Guirao, Hannah Ritchie and Max Roser (2023). 'Mental Health'. Available at: https://ourworldindata.org/mental-health
[22] Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Health Manage Forum. 2017 Mar;30(2):111-116. doi: 10.1177/0840470416679413. Epub 2017 Feb 16. PMID: 28929889; PMCID: PMC5347358.
[23] Wainberg ML, Scorza P, Shultz JM, Helpman L, Mootz JJ, Johnson KA, Neria Y, Bradford JE, Oquendo MA, Arbuckle MR. Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective. Curr Psychiatry Rep. 2017 May;19(5):28. doi: 10.1007/s11920-017-0780-z. PMID: 28425023; PMCID: PMC5553319.
[24] WHO. (2022). 'Mental disorders. Available at: https://www.who.int/news-room/fact-sheets/detail/mental-disorders
[25] Herman AA, Stein DJ, Seedat S, Heeringa SG, Moomal H, Williams DR. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. S Afr Med J. 2009 May;99(5 Pt 2):339-44. PMID: 19588796; PMCID: PMC3191537.
[26] Ipsos Global Health Service Monitor. (2023). Available at: Mental health is now the number one health problem, ahead of cancer and coronavirus | Ipsos

compared to 39% globally. It should, however, be noted that the Ipsos survey only sampled ~500 individuals who were mostly individuals living in urban areas with access to the internet, which may result in a biased view.

Figure 3: The impact of stress on South African's day to day life compared to global rates
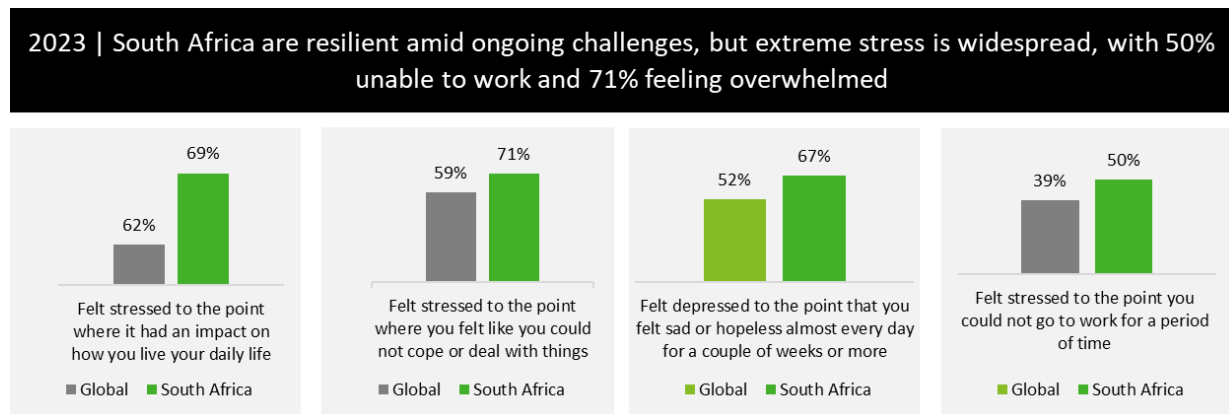
The high incidence and prevalence rates recorded in South Africa imply a high probability of individuals in South Africa facing mental health issues. This contributes to an increased mental health burden. The reported prevalence percentage are substantiated by the provincial prevalence percentage breakdown in Figure 4 (Craig et. al, 2022)[6].

Figure 4: Depression and Anxiety Prevalence by Province[6]
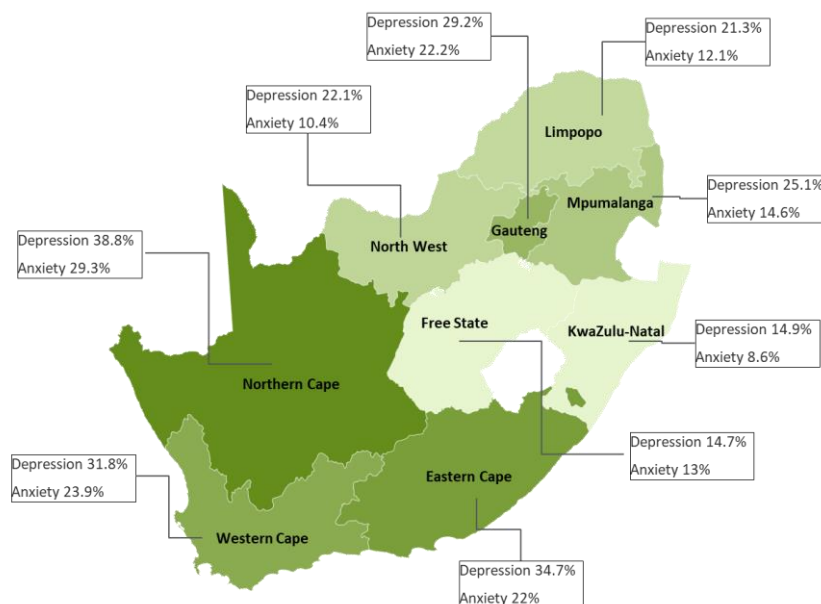
A national study conducted in 2022, estimated depression rates using the Patient Health Questionnaire-9 (PHQ-9) across a representative sample of South Africans with 3 402 respondents (Craig et. al, 2022). The results showed that, 25.7% of individuals in South Africa experienced symptoms associated with a mental health disorder (Craig et. al, 2022). According to the study, the Northern Cape province exhibits the highest rates of both probable depression (38.8%) and anxiety (29.3%) among all provinces, while the Free State province reports the lowest probable depression prevalence (14.7%), and KwaZulu-Natal reports the lowest probable anxiety

prevalence (8.6%). Urban-rural disparities are apparent with metropolitan areas showing depression prevalence of 53% compared to 23.8% in city/town settings and 22.5% in rural areas (Craig et. al, 2022)[6]. Limited availability of mental health facilities in rural regions may restrict access to services, potentially increasing the prevalence of mental health issues. Further discussion on service delivery in rural versus urban areas can be found in the service delivery section of this report.

While understanding the disease burden through prevalence is crucial, assession the burden based on current patients seeking care for mental health is also insightful. The District Health Information System (DHIS) provides information on all clients of all ages who attended ambulatory (non-inpatient) services for mental health conditions across these facilities in South Africa[27].

There is a clear difference in mental health care-seeking behavior across South African provinces between the periods 2017-2020 and 2021-2023 as seen in Figure 5. The previous years mostly saw steady or rising trends, while the recent years show a tendency of decrease or plateau in mental health care use. This overall drop implies possible change in factors affecting mental health care access and use, highlighting the need for continuous monitoring and specific interventions to deal with changing mental health needs efficiently.

Figure 5: Patients seeking care per 100 000 population by province over time [27]
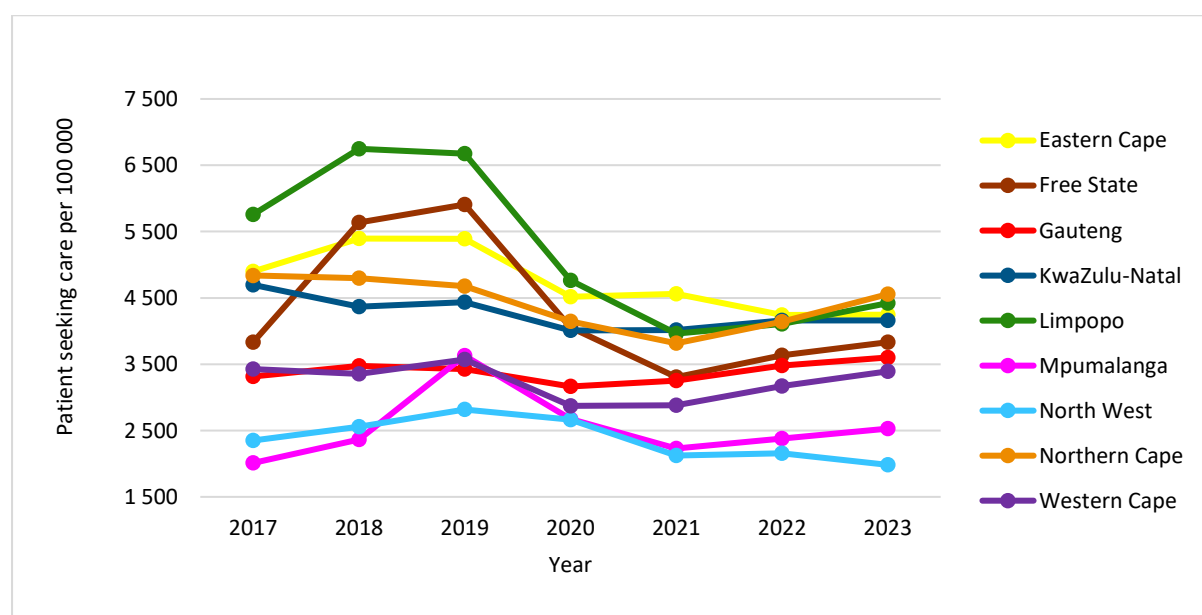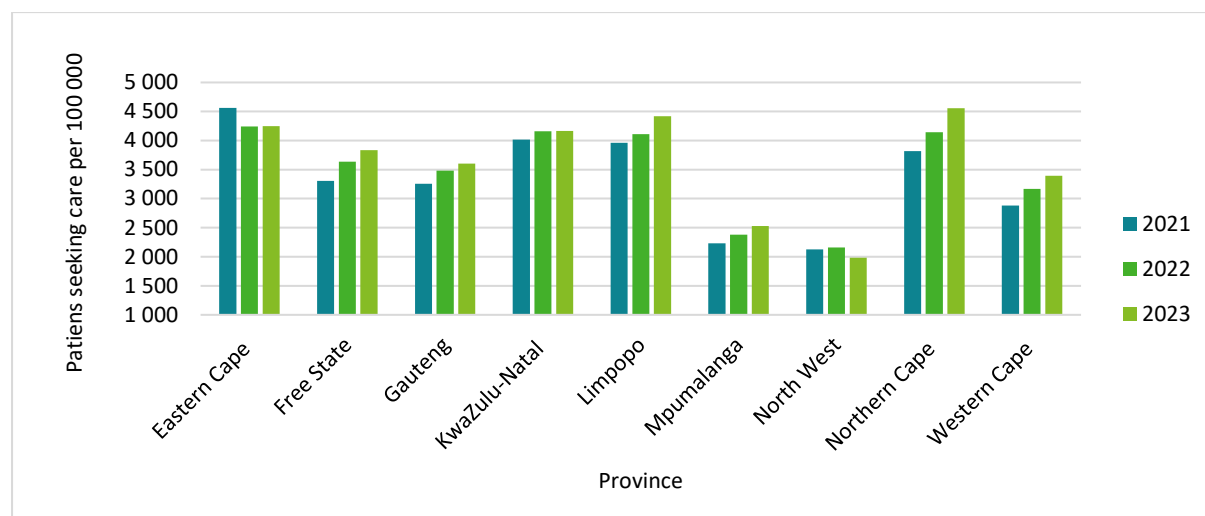

Figure 6 shows that in the last three years, there has been a noticeable increase in per capita patients who seek mental health care at outpatient facilities in most provinces of South Africa. While many provinces, such as the Free State, Gauteng, Limpopo, Mpumalanga, Northern Cape and Western Cape show a positive trend, indicating improved awareness and access to mental health services, there are still gaps with some provinces like the Eastern Cape and North West, seeing declines. These results highlight the need for specific interventions to

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[27] DHIS data extract (2017-2023). Provided via NDoH

overcome barriers to access and raise mental health awareness, ensuring fair allocation of resources and quality of care across the country.

The District Health Information System (DHIS) also provides information on the mental health admissions and out-patient services accessed over time across all facilities in South Africa.

The mental health separation rate assesses the proportion of clients admitted for mental health issues, excluding in-patient discharges, deaths, and transfers out. This metric offers an overview of the mental health workload in general hospitals, with trends over time providing insights into mental health admissions within these institutions. Figure 7 illustrated the trend analysis of mental health separation rates across provinces over the past five years.
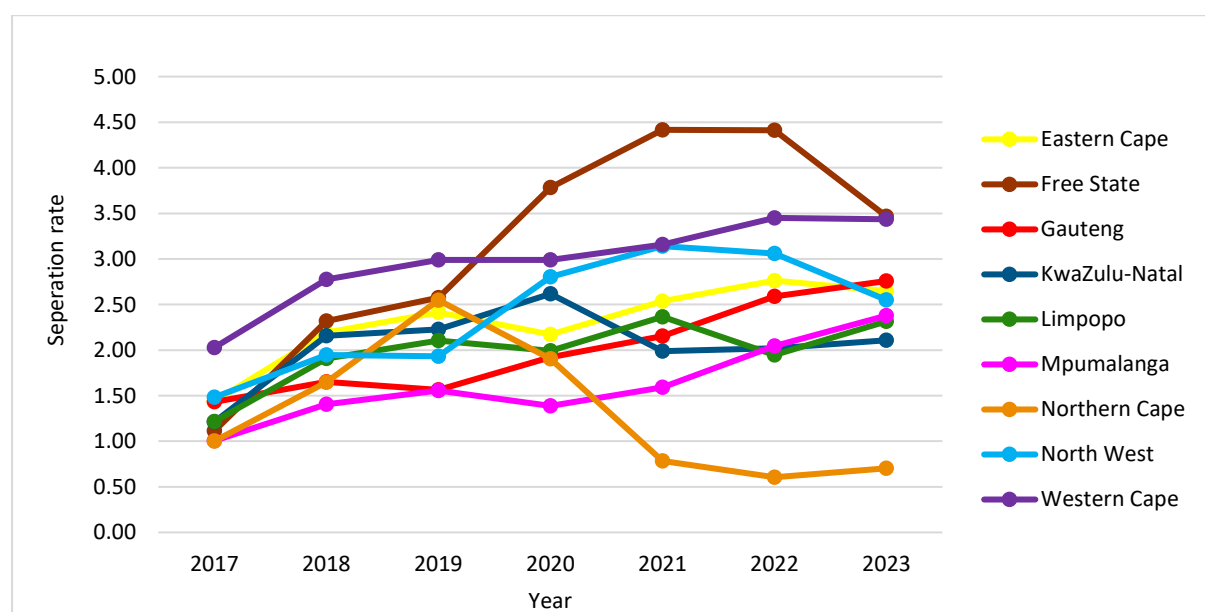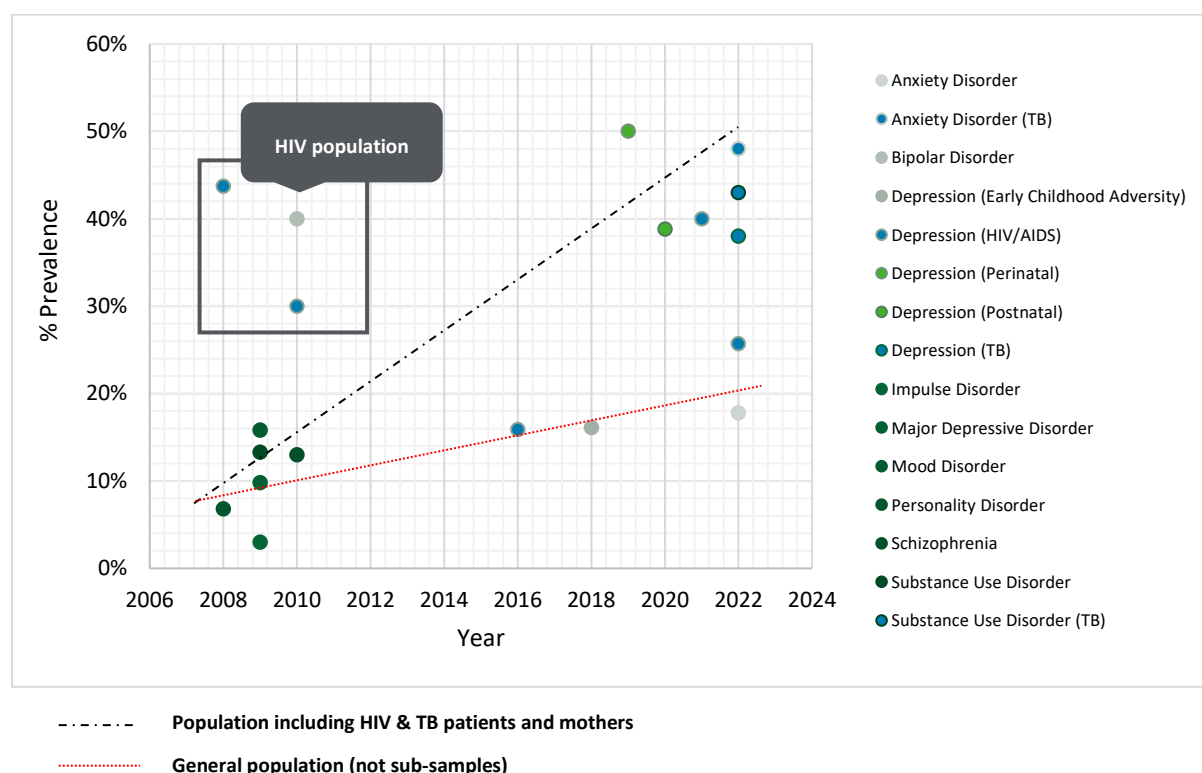
Overall, there is variation in separation rates across provinces and over time, reflecting fluctuations in the demand for inpatient mental health services. While some provinces, such as the Free State and Western Cape, show increasing trends in separation rates, others, like Mpumalanga and Northern Cape, exhibit more fluctuating patterns. The surge in workload observed in certain provinces can be attribute to the expansion of mental health services and resources, aimed at meeting the growing demand for inpatient care. Moreover, specific trends over the last three years reveal both increases and decreases in separation rates across provinces, indicating dynamic shifts in mental health service utilisation. These trends underscore the need for ongoing monitoring and tailored interventions to ensure effective management of inpatient mental health workload and equitable access to services across provinces. The exact reason for the decrease in mental health separation rates in the Northern Cape is uncertain, and further investigation will be necessary to gain a comprehensive understanding of this trend.

A view on mental disorder prevalence reporting in South Africa from 2008 – 2022

Figure 8: Mental Disorder Prevalence Reporting from 2008 to 2022*

– . – . – . – **Population including HIV & TB patients and mothers**

.... **General population (not sub-samples)**

*Additional detail on Figure 8 can be seen in Appendix A – this table incorporates the study name, sample size and study methodology.

As depicted in Figure 8 there have been various studies since 2008 reporting on the prevalence of several mental disorders in South Africa. Depression has been reported on nine times more than all other disorders. Anxiety disorder is second highest on the list of disorders being reported on – with a mere two studies. Looking at Figure 8 there is a clustering of studies around 2008 and then again around 2020. This could be a result of unique contextual events like the 2008 recession and the Covid-19 pandemic. These contextual events altered the lives of most South Africans and most likely allowed for a platform to report on mental health in South Africa as these

events may have had a significant impact on the mental health of South Africans. Additionally, looking at the results of these various studies over time it appears that rates of mental disorders and mental illnesses have been increasing, however it is important to note that these studies make use of different estimation tools and some use sub-populations such as mothers, and TB and/or HIV patients. When looking at the overall trend for the general population the trend while still increasing is lower than the trend for certain population groups (mothers, HIV/TB patients) showing that these population groups are at an even higher risk of experiencing mental health concerns. This result suggests that there is no resilient systematic screening or monitoring of mental disorders. Reporting on mental disorder prevalence will be more meaningful once the parameters of recording of this data is clearly defined and recording occurs more consistently.

One of the mental health epidemiology and research stakeholders confirmed during an interview that studies determining prevalence and incidence of mental and neurological disorders usually rely on self-diagnosis questionnaires with a defined cut-off point for individuals to be considered as experiencing depression symptoms and included in the prevalence estimate. To obtain a more accurate understanding of prevalence in a country, consultations with psychologists and psychiatrists is essential for making diagnoses. The current research on prevalence relies on self-diagnosed symptoms and only provides estimates. These studies ask people about their mental state at a single point in time, which may lead to over-inclusiveness for individuals experiencing certain emotions at the time of the survey but would return to their baseline emotions later.

DEMOGRAPHICS AND SOCIAL DETERMINANTS OF MENTAL HEALTH

The social determinants of health (SDOH) are the non-medical factors that influence health outcomes, encompassing conditions such as economic stability, education, employment, food security, housing, and social connections (WHO Health Organization, n.d.).[28]

Figure 9: The social determinants of health for everyone[25]
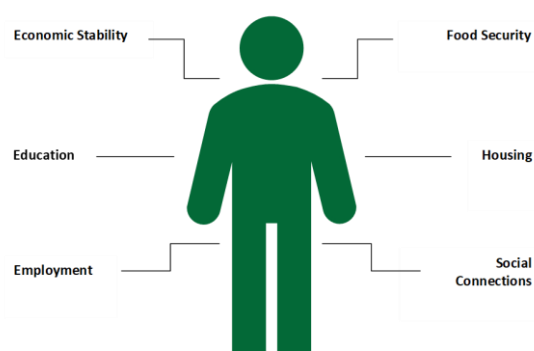
The evolution of SDOH has been shaped by early observations linking poverty and unsanitary living conditions to disease prevalence (Chadwick,1942)[29], as well as by social movements highlighting the role of injustice and

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[28] WHO, n.d. Available here: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[29] Chadwick, E. (1842). Report on the Sanitary Condition of the Labouring Population of Great Britain. Her Majesty's Stationery Office.

discrimination in health disparities (Marmot.et.al, 2006)[30]. Globalisation and urbanisation have raised awareness of global health disparities and the impact of rapid urbanisation on health (Commission on Social Determinants of Health, 2008)[31].

SDOH are crucial for understanding health as they explain a significant portion of health outcomes, highlight health inequities, guide interventions, and promote social justice (Braveman et al, 2011)[32,33]. Findings from a global systematic review study by Lunch & Kaplan 2000 underscore the importance of SDOH such as the link between higher education and better health outcomes, the impact of poverty on various health problems, the role of social support in buffering against stress, and the negative health consequences of discrimination.

Examples of the importance (Lynch & Kaplan, 2000)[34] of SDOH:

- Education attainment: Higher education is linked to better health outcomes, lower risks of chronic diseases, and longer life expectancy.
- Income: Poverty increases the risk of various health problems due to stress, limited access to healthy food and healthcare, and poor living conditions.
- Social support: Strong social connections provide emotional and practical support, buffering against stress and promoting physical and mental health.
- Discrimination: Racial, ethnic, and gender discrimination lead to chronic stress and negative health outcomes.

Analysing mental health through demographic determinants including gender, race, age, and residence type allows for a deeper understanding of how socioeconomic determinants intersect to shape mental health disparities.

Gender, race, and age

The U-Report of October 2023[35] a mobile-based survey aimed at the inclusion of young voices into mental health and was conducted across 25 837 individuals, with an 89% response rate. The report collected a range of 152 to 1543 responses across the nine provinces. Notably, individuals ages 20-24 had the highest percentage of respondents expressing the need for mental health support, as detailed in Figure 10 (U-Report, 2023)[35].

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[30] Kaplan, George A. "Social Determinants of Health, 2nd Edition. M Marmot and R Wilkinson (eds). Oxford: Oxford University Press, 2006, pp. 376, $57.50. ISBN: 9780198565895." International Journal of Epidemiology 35 (2006): 1111-1112.

[31] World Health Organization. (2023). About the Commission on Social Determinants of Health. [https://www.who.int/initiatives/action-on-the-social-determinants-of-health-for-advancing-equity/world-report-on-social-determinants-of-health-equity/commission-on-social-determinants-of-health]

[32] Braveman, P., Gottlieb, L., & Younge, S. (2011). Addressing the social determinants of health: a call to action. American Journal of Public Health, 101(10), 1521-1526.

[33] Whitehead, M., Dahlgren, G., & Whitehead, M. (2010). Levelling up: a policy framework for tackling social determinants and reducing health inequalities. World Health Organization.

[34] Lynch, J. W., & Kaplan, G. A. (2000). Socioeconomic position and health: why the link is plausible. Social Science & Medicine, 51(11), 1509-1518.

[35] Unicef. (2023). U-Report, South Africa. Available at: https://sa.ureport.in/

Figure 10: Age breakdown of U-Report respondents that needed mental health support[35]
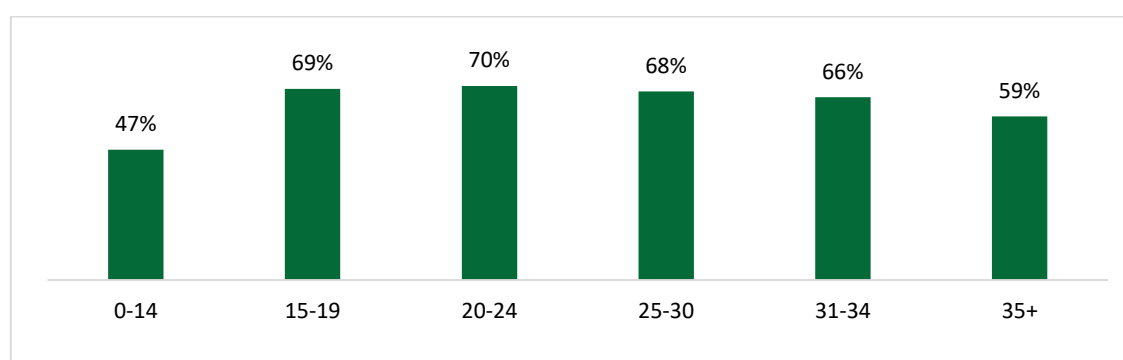
Adolescents and youth are considered vulnerable groups with more than 13% of adolescents aged between 10-19 years living with symptoms associated with a mental health condition compared to 25.7% in the general population. In addition, almost 46,000 adolescents die from suicide each year, among the top five causes of death for their age group (Unicef, 2022)[36]. The National Department of Health has acknowledged the significance of addressing mental health concerns among children and adolescents. In 2023, they mandated the inclusion of a specific variable to record rates of suicide attempts in the age group across all healthcare facilities within the District Health Information System (DHIS).

Based on a 2010 analysis of the South African Stress and Health (SASH) Survey, Jackson et. al ,2010[37] found that black South Africans are more likely to experience anxiety and stress when compared to other population groups. Similar results have been reported by Harriman, Williams and Morgan (2022)[38] using the South African National Health and Nutrition Examination Survey which measured psychological distress using the Kessler-10 scale.

Additionally, black South Africans are considered a vulnerable group experiencing high levels of poverty, unemployment and making up the majority living in rural areas when compared to other demographic groups (de Villiers, 2010[39]; Mngoma and Ayonrinde, 2023[40] and Vogel et. al, 2021[41]). These factors may result in black South Africans being predisposed to developing mental health conditions through the various social causation pathways whereby living in poverty not only influences one's financial status, but also ones living conditions, education, and health outcomes. The interconnectedness of race, socioeconomic status, and geography plays a pivotal role in shaping mental health outcomes. Recognising and addressing these complex intersections is

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[36] Unicef. (2022). Highlighting the importance of child and adolescent mental health
. Available at: https://www.unicef.org/southafrica/stories/highlighting-importance-child-and-adolescent-mental-health#:~:text=In%20addition%2C%20almost%2046%2C000%20adolescents,the%20University%20of%20Cape%20Town.
[37] Jackson PB, Williams DR, Stein DJ, Herman A, Williams SL, Redmond DL. Race and psychological distress: the South african stress and health study. J Health Soc Behav. 2010 Dec;51(4):458-77. doi: 10.1177/0022146510386795. PMID: 21131621; PMCID: PMC3307586
[38] Harriman, N.W., Williams, D.R., Morgan, J.W. *et al.* Racial disparities in psychological distress in post-apartheid South Africa: results from the SANHANES-1 survey. *Soc Psychiatry Psychiatr Epidemiol* **57**, 843–857 (2022). https://doi.org/10.1007/s00127-021-02175-w
[39] de Villiers, K. Bridging the health inequality gap: an examination of South Africa's social innovation in health landscape. *Infect Dis Poverty* **10**, 19 (2021). https://doi.org/10.1186/s40249-021-00804-9
[40] Mngoma NF, Ayonrinde OA. Mental distress and substance use among rural Black South African youth who are not in employment, education or training (NEET). Int J Soc Psychiatry. 2023 May;69(3):532-542. doi: 10.1177/00207640221114252. Epub 2022 Jul 28. PMID: 35903872; PMCID: PMC10152210.
[41] Vogel, C., Maree, G., Köhler, T., Stanwix, B., Bhorat, H., Sodi, T., Ubomba-Jaswa, E., Drimie, S., Mbhenyane, X., Symington, E., Adebayo, P. & Ndinda, C., 2021. Impact on vulnerable groups. South Africa Covid-19 Country Report [Interim draft]. DPME (Department of Planning, Monitoring and Evaluation), GTAC (Government Technical Advisory Centre) & NRF (National Research Foundation), Pretoria: May

essential in delivering targeted and effective interventions to mitigate mental health disparities among vulnerable populations.

According to the U-report conducted in South Africa, 70% of women and 65% of men have reported a need for mental health support (U-Report, 2023)[35]. A cross-sectional study conducted in 2021 in informal settlements in South Africa, estimating the risk factor for generalised anxiety disorders (GAD) among a representative sample of men and women in Durban, found equally similar rates between men (19.6%) and women (18.6%) experiencing GAD (Mkhwanazi and Gibbs, 2021)[42]. However, it has been noted in literature publications that women generally have greater health seeking behaviours compared to men, resulting in higher awareness, diagnosis, and treatment for mental health care for women compared to men (Sagar-Ouriaghil et. al, 2019 and Chatmon, 2020)[43,44]. The results align with the fact that men are four times more likely to die from suicide than women (South African Federation for Mental Health, 2023)[45]. While these results point to men as a priority group for mental health, women who bear children in their life are additionally predisposed to developing pre- and post-natal depression (Wardoyo et. al, 2023 and World Economic Forum, 2021)[46,47]. It is important to consider that gender-specific prevalence of mental illness cannot be examined in isolation. In South Africa, cultural and social factors may influence how mental health issues are perceived and addressed for men and women. As mentioned, while some studies suggest men may be less likely to seek help due to stigma, women are predisposed to pre- and post-natal depressing. Recognising that mental health challenges can affect people of all genders is essential.

Mother and child

In South Africa the burden of mental illness extends to both mothers and their children, with common mental disorders affecting 20-40% of women during the perinatal period, leaving them vulnerable to anxiety, depression, and even postpartum psychosis (Turner & Honickman, 2016)[48]. This high prevalence can be attributed to various factors, including poverty, violence, and limited accessibility to mental health services[48]. Children in South Africa face significant mental health challenges. Children experiencing a psychiatric disorder

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[42] Smanga Mkhwanazi, Andrew Gibbs,Risk factors for generalized anxiety disorder among young women and men in informal settlements in South Africa: A cross-sectional study,SSM - Mental Health,Volume 1,2021,100010,ISSN 2666-5603,https://doi.org/10.1016/j.ssmmh.2021.100010.(https://www.sciencedirect.com/science/article/pii/S2666560321000104)

[43] Sagar-Ouriaghli I, Godfrey E, Bridge L, Meade L, Brown JSL. Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. Am J Mens Health. 2019 May-Jun;13(3):1557988319857009. doi: 10.1177/1557988319857009. PMID: 31184251; PMCID: PMC6560805.

[44] Chatmon BN. Males and Mental Health Stigma. Am J Mens Health. 2020 Jul-Aug;14(4):1557988320949322. doi: 10.1177/1557988320949322. PMID: 32812501; PMCID: PMC7444121.

[45] SAFMH, (2022). 'EXPLAINER SERIES: MEN AND MENTAL HEALTH'. Available at: https://www.safmh.org/explainer-series-men-and-mental-health/#:~:text=In%20South%20Africa%2C%20men%20are,expectations%20for%20men%20and%20women.

[46] Wardoyo H, Moeloek ND, Basrowi RW, Ekowati M, Samah K, Mustopo WI, Nurdjasmi E, Widyahening IS, Medise BE, Darus F, Sundjaya T, Pelangi B. Mental Health Awareness and Promotion during the First 1000 Days of Life: An Expert Consensus. Healthcare (Basel). 2023 Dec 24;12(1):44. doi: 10.3390/healthcare12010044. PMID: 38200950; PMCID: PMC10778627.

[47] World Economic Forum, (2021). '4 facts you didn't know about mental health in Africa'. Available at: https://www.weforum.org/agenda/2021/08/4-facts-mental-health-africa/

[48] TURNER, R E; HONIKMAN, S. Maternal mental health and the first 1 000 days. South African Medical Journal, [S.l.], v. 106, n. 12, p. 1164-1167, dec. 2016. ISSN 2078-5135. Available at: <http://www.samj.org.za/index.php/samj/article/view/11610/7758>. Date accessed: 15 Feb. 2024. doi:10.7196/SAMJ.2017.v106i12.12129.

has also increased (Unicef, 2022)[49]. Often trauma-related disorders due to widespread violence and exposure to adverse events are further exacerbated by limited mental health support (Turner & Honickman, 2016)[48].

Research indicates that children of depressed mothers are predisposed to experiencing poor health outcomes, academic difficulties, and increased susceptibility to depression themselves (Turner & Honickman, 2016 and Pellowski et. al, 2019)[48,50]. In South Africa, only one in ten children diagnosed with a mental condition that is treatable will have access to care, hindering academic success and future economic prospects (World Economic Forum, 2021)[47]. The interplay between maternal and child mental health issues is complex. Prioritising mental health services, particularly during pregnancy and early childhood, is crucial to effectively address this complex interaction.

Poverty and unemployment

Mental health problems in low- or middle-income countries is a growing health concern. In South Africa, a middle-income country with significant income disparity, nearly 1 in 5 adults were reported to suffer from impaired mental health, with less than a quarter of this population ever seeking mental health treatment (Craig et. al, 2022)[6].

For example, Craig et. al (2022)[6] highlights that the Eastern Cape one of the poorest provinces in South Africa with 67.3% adults living below the poverty line (StatsSA, 2019)[51], recorded one of the highest lifetime prevalence rates of depression symptoms at 31.4%[6]. Geographic disparities in poverty and unemployment rates are seen to significantly contribute to a higher likelihood of mental illness among individuals residing in selected provinces. Northern Cape has the highest reported prevalence of both probable depression and probable anxiety among the nine provinces in South Africa (Craig et. al, 2022)[6]. This is likely attributed to the prevalence of poverty and unemployment, especially in rural areas where agriculture is significant. The Northern Cape province (37.1%) stands out due to its substantial share of commercial agricultural land in South Africa (StatsSA, 2019)[52].

Research on the social determinants of health shows that there is a strong relationship between the population's health and economic productivity. Sick individuals are more likely to lose income through both the direct and indirect costs associated with their illness (Chelak & Chakole, 2023)[53].This relationship between poverty and mental has been extensively discussed by Lund et. al (2011)[54] and Knifton & Inglis (2020)[55] illustrating the vicious

[49] Unicef. (2022). Highlighting the importance of child and adolescent mental health. Available at: https://www.unicef.org/southafrica/stories/highlighting-importance-child-and-adolescent-mental-health#:~:text=In%20addition%2C%20almost%2046%2C000%20adolescents,the%20University%20of%20Cape%20Town.
[50] Pellowski JA, Bengtson AM, Barnett W, DiClemente K, Koen N, Zar HJ, Stein DJ. Perinatal depression among mothers in a South African birth cohort study: Trajectories from pregnancy to 18 months postpartum. J Affect Disord. 2019 Dec 1;259:279-287. doi: 10.1016/j.jad.2019.08.052. Epub 2019 Aug 19. PMID: 31454590; PMCID: PMC6851529.
[51] StatsSA, (2019). ' Five facts about poverty in South Africa' . Available at: https://www.statssa.gov.za/?p=12075
[52] StatsSA, (2020), '*Stats SA releases Census of Commercial Agriculture 2017 Report*'. Available at: https://www.statssa.gov.za/?p=13144#:~:text=The%20Northern%20Cape%20province%20accounted,%25)%20recorded%20the%20smallest%20shares.
[53] Chelak K, Chakole S. The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review. Cureus. 2023 Jan 5;15(1):e33425. doi: 10.7759/cureus.33425. PMID: 36751221; PMCID: PMC9899154.
[54] Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Knapp M, Patel V. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. Lancet. 2011 Oct 22;378(9801):1502-14. doi: 10.1016/S0140-6736(11)60754-X. Epub 2011 Oct 16. PMID: 22008425.
[55] Knifton L, Inglis G. Poverty and mental health: policy, practice and research implications. BJPsych Bull. 2020 Oct;44(5):193-196. doi: 10.1192/bjb.2020.78. PMID: 32744210; PMCID: PMC7525587.

cycle which exists between mental disorders and poverty. A depiction of this cycle can be seen in Figure 11 below:

Figure 11: Poverty and mental health causation pathway[54]
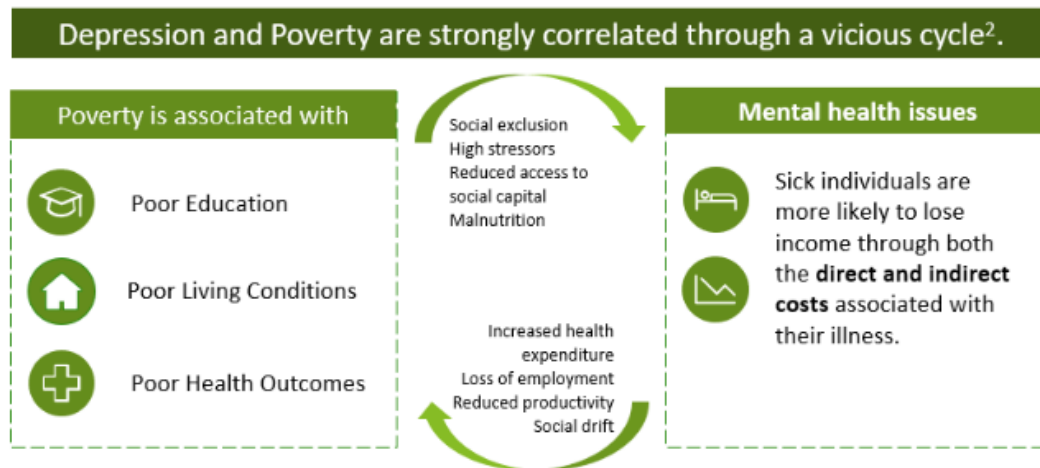
Individuals who suffer from a mental illness are more likely to drift into or remain in poverty because of reduced productivity, loss of employment, and increased health expenditure, known as the social drift pathway (Garman, 2020)[5.] So, poverty leads to poorer mental health – and vice versa – leading, in turn, to reduced opportunities for economic development and increasing the risk of lifelong poverty (Garman, 2020)[5]. Research done by the University of Cape Town on the social determinants of health shows that there is a strong relationship between the population's health and economic productivity. Sick individuals are more likely to lose income through both the direct and indirect costs associated with their illness (Garman, 2020)[5.] Mental health and poverty are therefore interlinked, contributing to a cycle that hinders opportunities for people to manage their mental health and move out of poverty (Garman, 2020)[5.] This phenomenon is known as the social causation pathway (depicted in Figure 11) and is driven by stress, social exclusion, decreased social capital, and increased exposure to violence and trauma among those facing adversity.

This pathway impacts not only adults, but also adolescents, a demographic undergoing pivotal social, emotional, and behavioural transitions. For young people residing in poverty, educational attainment, employment prospects, and goal achievement are often elusive, restricting life opportunities and heightening susceptibility to mental health illness (Garman, 2020)[5.] South Africa has an escalating unemployment rate, which has risen steadily over recent years climbing from the lowest recorded unemployment rate in 2008 of 21.5% to a staggering 34.4% in 2021, 29.81% in 2022 and 32.6% in 2023 (Stats SA,2023)[56]. The Covid-19 pandemic worsened the economic recession, reduced job availability and increased food insecurity.

"At any given time, point, people experiencing household hunger have higher levels of depressed mood than people not experiencing household hunger."

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[56] StatsSA, (2023). *'Statistics South Africa on Quarterly Labour Force Survey quarter three 2023'* Available at: https://www.gov.za/news/media-statements/statistics-south-africa-quarterly-labour-force-survey-quarter-three-2023-14

Research related to South Africa emphasises hunger's substantial role in poor mental health, with studies indicating elevated depression levels among those experiencing hunger (Dlamini et. al, 2023 and Hunt, Breet & Stein, 2021)[57,58].

Not only does South Africa face persistent poverty, significant wealth disparities, high levels of violence, there is also a substantial burden of both communicable and non-communicable diseases. These factors expose a significant portion of the population to a continuous risk of developing anxiety, depression, and traumatic stress disorders.

Quadruple burden of disease

The surge in mental illness in South Africa correlates with the prevalence of various communicable diseases and HIV/AIDS and TB, as well as several non-communicable diseases such as diabetes and cardiovascular disease (National Department of Health, 2021)[59]. South Africa has a large communicable and non-communicable disease burden with the quadruple burden of disease term used to capture the significant HIV/AIDS and TB, mother and child health, non-communicable diseases and violence and injury burden experienced by South Africa (Roomaney et. al, 2019; Khoza-Shangase, 2020 and Roomaney et. al, 2022)[60,61,62]. South Africa reports a HIV prevalence rate of 12.7% for (Human Sciences Research Council, 2023)[63], and ranks among the top 30 countries globally with the highest burden of tuberculosis (Conana et. al, 2022)[64]. Nearly 30% of adults live with at least one non-communicable disease (Mayosi et. al, 2009)[65]. The biological impact of these diseases can cause neurological damage and increase vulnerability to mental disorders like depression and anxiety (Hayward et. al, 2022 and Remien et. al, 2019)[66,67].

This is evident in the fact that over 40% of people living with HIV in South Africa have a diagnosable mental disorder (SACAP,2019)[68]. Studies by Stewart et. al, 2014[69] have found that individuals living with cardiovascular disease are twice as likely to experience depression or anxiety. There are elevated rates of depression among

[57] Dlamini SN, Craig A, Mtintsilana A, et al. Food insecurity and coping strategies and their association with anxiety and depression: a nationally representative South African survey. *Public Health Nutrition*. 2023;26(4):705-715. doi:10.1017/S1368980023000186

[58] Hunt, Xanthe, Dan J Stein, Nic Spaull, and Mark Tomlinson. "Hunger as a driver of depressive symptoms: Optimising responses to mental health aspects of the COVID-19 pandemic." South African Medical Journal (2021).

[59] South Africa. National Department of Health (2021). *National User Guide on the Prevention and Treatment of Hypertension in Adults at the PHC level (South Africa)*. Pretoria. Available at: ccsbrief_zaf_en.pdf

[60] Roomaney RA, van Wyk B, Cois A, Pillay-van Wyk V. Multimorbidity Patterns in a National HIV Survey of South African Youth and Adults. Front Public Health. 2022 Apr 4;10:862993. doi: 10.3389/fpubh.2022.862993. PMID: 35444991; PMCID: PMC9015099.

[61] Khoza-Shangase, Katijah. (2020). Burden of disease: A scoping review of HIV/AIDS and TB in occupational noise-induced hearing loss. *South African Journal of Communication Disorders*, 67(2), 1-9. https://dx.doi.org/10.4102/sajcd.v67i2.669

[62] Roomaney R. A., van Wyk B., Cois A., Pillay-van Wyk V. (2022). Inequity in the Distribution of Non-Communicable Disease Multimorbidity in Adults in South Africa: An Analysis of Prevalence and Patterns International Journal of Public Health. Volume 67. DOI: 10.3389/ijph.2022.1605072

[63] Human Sciences Research Council, (2023). 'New HIV Survey Highlights Progress and Ongoing Disparities in South Africa's HIV Epidemic'. Available at: https://hsrc.ac.za/press-releases/hsc/new-hiv-survey-highlights-progress-and-ongoing-disparities-in-south-africas-hiv-epidemic/

[64] Conan N, Simons E, Ohler L, Mbatha M, van Cutsem G, Huerga H. Prevalence of TB and health-seeking behaviour. Int J Tuberc Lung Dis. 2022 May 1;26(5):463-465. doi: 10.5588/ijtld.22.0001. PMID: 35505477; PMCID: PMC9067428.

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[66] Hayward SE, Deal A, Rustage K, Nellums LB, Sweetland AC, Boccia D, Hargreaves S, Friedland JS. The relationship between mental health and risk of active tuberculosis: a systematic review. BMJ Open. 2022 Jan 6;12(1): e048945. doi: 10.1136/bmjopen-2021-048945. PMID: 34992103; PMCID: PMC8739435.

[67] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420. doi: 10.1097/QAD.0000000000002227. PMID: 30950883; PMCID: PMC6635049.

[68] South African College of Applied Psychology. (2019).' The Shocking State of Mental Health in South Africa'. Available at: https://www.sacap.edu.za/blog/management-leadership/mental-health-south-africa/

[69] Stewart JC, Rollman BL. Optimizing approaches to addressing depression in cardiac patients: a comment on O'Neil et al. Ann Behav Med. 2014 Oct;48(2):142-4. doi: 10.1007/s12160-014-9615-x. PMID: 24722962; PMCID: PMC4156893.

cancer patients (Steffen et. al, 2020)[70]. A study by Cordova et. al (2017)[71] found that 15% of cancer patients experience post-traumatic stress disorders and patients with cancer are also significantly more likely to experience depression, with prevalence varying across studies based on stage of cancer, and different study methodologies used (Caruso et. al, 2017)[72]. With respect to other non-communicable diseases such as diabetes, the Centre for Disease Control and Prevention indicates that people with diabetes are 2 to 3 times more likely to develop depression than people without diabetes (CDC, n.d.)[73] putting diabetes patients at an increased risk to treatment adherence.

A systematic review and meta-analysis conducted for the Sub-Saharan African region and published in 2017, revealed that nearly 1 in 3 individuals with stroke in this area experiences clinical depression, highlighting the intricate interaction between physical and psychiatric health outcomes. Despite limitations surrounding the quality of identified studies, the findings of this review coincide with those reported in the global literature. (Ojagbemi et. al, 2017)[74].

In addition to illnesses covered in the quadruple burden of disease and its link to living with mental health issues, individuals with physical disabilities are also predisposed to developing mental health issues (Centre for Disease Control, 2020)[75].

Disability Status

In South Africa, the disabled population exhibits higher prevalence rates due to factors like physical and sensory limitations fostering feelings of isolation, frustration, and dependence, stigma and discrimination exacerbating social and emotional strain, and limited access to education, employment, and healthcare. This creates a cycle of poverty and social exclusion, impacting mental well-being (Trani et. al, 2020 and Suliman et. al, 2010)[76,77].

A review of the 2011 census included in the South African Child Gauge study indicates a national disability prevalence rate of 7.5% in South Africa, with rates among children ranging from 11% for 5 – 9-year-olds, 4% for 10 – 14-year-olds and 3% for 15 – 19-year-olds (Jamieson, Berry and Lake, 2017)[78]. According to this study children and adolescents with physical or intellectual disabilities face elevated risks of developing mental health problems.

[70] Steffen A., Nübel J., Jacobi F., Bätzing J., Holstiege J. Mental and somatic comorbidity of depression: A comprehensive cross-sectional analysis of 202 diagnosis groups using German nationwide ambulatory claims data. *BMC Psychiatry.* 2020;20:142. doi: 10.1186/s12888-020-02546-8.
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[76] Trani JF, Moodley J, Anand P, Graham L, Thu Maw MT. Stigma of persons with disabilities in South Africa: Uncovering pathways from discrimination to depression and low self-esteem. Soc Sci Med. 2020 Nov; 265:113449. doi: 10.1016/j.socscimed.2020.113449. Epub 2020 Oct 21. PMID: 33183862; PMCID: PMC7576188.
[77] Suliman, Sharain MA*; Stein, Dan J. MD, PhD†; Myer, Landon PhD‡; Williams, David R. PhD§; Seedat, Soraya MD, PhD*. Disability and Treatment of Psychiatric and Physical Disorders in South Africa. The Journal of Nervous and Mental Disease 198(1): p 8-15, January 2010. | DOI: 10.1097/NMD.0b013e3181c81708
[78] Jamieson L, Berry L & Lake L (eds) (2017) South African Child Gauge 2017. Cape Town: Children's Institute, University of Cape Town.

A 2011 study in South Africa found that mental disorders were more disabling than physical disorders, with the degree of disability increasing with the number of comorbid disorders. Depression consistently seemed to have a bigger impact on daily life than any other physical illness. Despite high rates of mental disorders and associated disability in South Africa, individuals with mental illness are less likely to receive treatment compared to those with physical health issues (Carpenter, Nyirenda and Hanass-Hancock, 2022) [79].

Sexual Orientation

In South Africa, the LGBTQ+ community faces a disproportionate burden of mental health challenges compared to the general population, hindering access to appropriate support, as reported in a literature review published in 2021 (Moagi et. al, 2021)[80]. Minority stress, fuelled by heteronormative pressure, causes chronic stress for LGBTQ+ individuals. Intersectionality worsens their experiences, adding layers of marginalisation due to factors like race, socioeconomic status, or disability, compounding mental health risks (Moagi et. al, 2021) [80]. Studies shows higher rates of depression, anxiety, and suicide among LGBTQ+ South Africans compared to the general population (Müller and Daskilewicz,2018 [81] and Lamontagne, Leroy and Yakusik, 2024[82]). Müller and Daskilewicz (2018) asked participants about their socio-demographic characteristics and experiences of violence and mental health outcomes as measured by CES-D 10 for depression and GAD-7 for anxiety. This study was conducted in 4 countries, including South Africa. In South Africa, where 832 LGBTI+ individuals were sampled, 57% showed signs of depression and 66% showed signs of anxiety. 12% had signs of alcohol dependence, and 5% signs of dependence on other drugs. Additionally, 27% had attempted suicide in the past year.

Lamontagne, Leroy and Yakusik, 2024 conducted a study on a sample of 108, 389 gay, bisexual and queen men as well as transfeminine people from 161 countries through a cross-sectional internet survey. Using a multinomial logistic regression for each group the study found that 30% of participants reported experiencing moderate to severe symptoms of anxiety and depression. Higher severity was found across transfeminine people (39%) and queer or questioning people (34.8%). Furthermore, transgender individuals face unique challenges like gender dysphoria and limited access to gender-affirming healthcare, which can exacerbate mental health struggles (University of Pretoria, 2021)[83].

In addition to sociodemographic variables predisposing individuals to developing mental health issues there are other more nuanced risk factors which can increase an individual's probability of developing mental health issues. These risk factors include an individual's family mental health history, whether the individual has

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[79] Bradley Carpenter, Makandwe Nyirenda & Jill Hanass-Hancock (2022) Disability, a priority area for health research in South Africa: an analysis of the burden of disease study 2017, Disability and Rehabilitation, 44:25, 7839-7847, DOI: 10.1080/09638288.2021.2000047

[80] Moagi MM, van der Wath AE, Jiyane PM, Rikhotso RS. Mental health challenges of lesbian, gay, bisexual and transgender people: An integrated literature review. Health SA. 2021 Jan 20; 26:1487. doi: 10.4102/hsag. v26i0.1487. PMID: 33604059; PMCID: PMC7876969.

[81] A Müller, K Daskilewicz, Mental health among lesbian, gay, bisexual, transgender and intersex people in East and Southern Africa, *European Journal of Public Health*, Volume 28, Issue suppl_4, November 2018, cky213.794, https://doi.org/10.1093/eurpub/cky213.794

[82] Lamontagne, E., Leroy, V., Yakusik, A. *et al.* Assessment and determinants of depression and anxiety on a global sample of sexual and gender diverse people at high risk of HIV: a public health approach. *BMC Public Health* **24**, 215 (2024). https://doi.org/10.1186/s12889-023-17493-8

[83] University of Pretoria. (2021). 'Queer Mental Health: Some Strategies for Proactive Care', Psychology – News, 31 October. Available at: https://www.up.ac.za/psychology/news/post_3029579-queer-mental-health-some-strategies-for-proactive-care

experienced early life adversity, the impact of stigma and culture on mental wellbeing and accessing services and stressful life events and social isolation.

Family Mental Health History

Family history of mental illness significantly influences individual mental health, from genetics to shared environments marked by stress, stigma, and limited resources. Witnessing parental struggles can heighten children's anxiety, triggering their own vulnerabilities. Additionally, intergenerational patterns are especially pronounced in mental health where family dynamics can perpetuate unhealthy behaviours (Landstedt and Almquist, 2019)[84]. A study conducted by Wooyoung Kim et. al (2023)[85] tracked mother and child pairs over time of participants in the Birth-to-Twenty longitudinal birth cohort study in Soweto where pregnant women were prospectively enrolled in 1990 and completed questionnaires on their mental wellbeing. The children of these mothers were assessed for psychiatric morbidity when they were 17-18 years old. The results showed that pregnant women who reported greater trauma exposure during Apartheid had children who exhibited greater psychiatric morbidity during late adolescence. Similar results have been reported by Eyal, Burns and Geyal (2018)[86] using the Center for Epidemiological Studies Short Depression Scale (CES-D 10) to determine the presence of depression among individuals. These results correlate with the outcomes discussed regarding women's encounters with prenatal and postnatal depression. This study sought to estimate the size of intergenerational transmission and found adolescent children of depressed mothers were seven times more likely to suffer from depression compared to those without depressed mothers. The study found that parental mental health was the single largest determinant of adolescent depression with paternal transmission of depression having a more significant impact on children than maternal depression.

Early intervention like psychoeducation and support groups, can equip children with coping mechanisms and reduce their vulnerability, while addressing stigma and socioeconomic factors fostering access to treatment.

Early life adversity

Early life adversity (ELA) significantly increases the prevalence of mental health illness, compared to those with less adverse early experiences.

Early Life Adversity (ELA) disrupts normal stress responses, raising depression and anxiety risks. Prolonged adversity triggers toxic stress, altering the brain structure and hindering emotional regulation. Individuals with limited coping skills are especially vulnerable to developing mental health issues. Limited coping skills usually occur in individuals with low levels of education, self-confidence and critical thinking skills often developed during one's formative years in a healthy upbringing. Socioeconomic factors further compound challenges, perpetuating adversity, and mental health struggles into adulthood. For example, individuals with low levels of

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[84] Landstedt, E., Almquist, Y.B. Intergenerational patterns of mental health problems: the role of childhood peer status position. *BMC Psychiatry* **19**, 286 (2019). https://doi.org/10.1186/s12888-019-2278-1

[85] Kim AW, Said Mohamed R, Norris SA, Richter LM, Kuzawa CW. Psychological legacies of intergenerational trauma under South African apartheid: Prenatal stress predicts greater vulnerability to the psychological impacts of future stress exposure during late adolescence and early adulthood in Soweto, South Africa. J Child Psychol Psychiatry. 2023 Jan;64(1):110-124. doi: 10.1111/jcpp.13672. Epub 2022 Jul 19. PMID: 35853622; PMCID: PMC10083984.

[86] Eyal, K., Burns, J., Geel, J. (2018). The intergenerational transmission of depression in South African adolescents: A cross-sectional longitudinal study. Cape Town: SALDRU, UCT. (SALDRU Working Paper Number 200, Version 2).

education or who live in poverty are more likely to experience early life adversity and less likely to have the necessary skillsets to seek help and treatment, causing mental health issues to stay with them into adulthood (Turner & Honickman, 2016)[48].

A study by Bruwer et. al (2014)[87] using SASH study results found that more than a third of respondents with suicidal behaviour experienced at least one childhood adversity with psychical abuse, parental death and parental divorce being the most prevalent adversities. The study revealed that two or more childhood adversities were associated with a twofold higher risk of lifetime suicide attempts, with sexual abuse, parental divorce and childhood physical abuse showing the strongest associations with lifetime suicide attempts.

This complex interplay emphasises the crucial need for early intervention and preventative measures. Investing in programmes promoting nurturing environments, trauma-informed support, and healthy coping mechanisms disrupts ELA and mental illness cycles. Addressing social and economic disparities is essential for equitable support, ensuring mental health challenges are not determined by early adversity.

Stigma and other cultural/contextual consideration

In South Africa, mental health issues already pose a significant burden. However, the added weight of stigma creates an even more formidable barrier to well-being. Stigma manifests in various forms and has profound negative consequences for individuals and society. In South Africa, stigma exacerbates mental health challenges by fostering psychological distress, delaying help-seeking behaviour, limiting access to resources, and deepening social and economic disparities (Alemu et. al, 2023)[88]. Stigma intensifies existing conditions, discourages timely access to healthcare services, constrains treatment availability, and leads to social exclusion and economic hardship.

A 2021 study conducted by Monnapula and Petersen (2021)[89] on mental health stigma experiences of caregivers and service users in South Africa found that caregivers often withhold the patient's diagnosis from the community out of fear of being stigmatised which can negatively impact treatment seeking behaviour. Another study which focused on a selected community in the iLembe district in KwaZulu-Natal found that individuals with mental health issues faced stigma from their communities in the form of isolation, blame and exploitation as well as labelling and stereotyping (Nxumalo and Mchunu, 2017)[90].

Self-stigma can cause further damage to an individual's self-esteem and ability to cope, leading to a cycle of hardship. To combat stigma related to mental health in South Africa, it is essential to raise awareness and educate people about mental illness, promote accurate media portrayals, launch targeted anti-stigma campaigns, strengthen mental health services to ensure culturally competent care, and advocate for policy

[87] Bruwer B, Govender R, Bishop M, et al. Association between childhood adversities and long-term suicidality among South Africans from the results of the South African Stress and Health study: a cross-sectional study. BMJ Open 2014;4:e004644. doi:10.1136/bmjopen-2013- 004644

[88] Alemu, W.G., Due, C., Muir-Cochrane, E. et al. Internalised stigma among people with mental illness in Africa, pooled effect estimates and subgroup analysis on each domain: systematic review and meta-analysis. BMC Psychiatry 23, 480 (2023). https://doi.org/10.1186/s12888-023-04950-2.

[89] Monnapula-Mazabane P, Petersen I. Mental health stigma experiences among caregivers and service users in South Africa: a qualitative investigation. Curr Psychol. 2023;42(11):9427-9439. doi: 10.1007/s12144-021-02236-y. Epub 2021 Aug 27. PMID: 34465971; PMCID: PMC8396139.

[90] Nxumalo CT, Mchunu GG. Exploring the stigma related experiences of family members of persons with mental illness in a selected community in the iLembe District, KwaZulu-Natal. Health SA Gesondheid. 2017;22:202–212. https://doi.org/10.1016/j.hsag.2017.02.002

change (Gumede, 2021)[91]. These efforts aim to develop empathy, encourage normalisation of mental health experiences, promote help-seeking behaviour, eliminate obstacles to care, and bring about systemic change, ultimately leading to better mental health outcomes for all individuals.

NGOs and NPOs play an active role in reducing stigma associated with mental health. For instance, organisations like the South African Depression and Anxiety Group (SADAG) provide helplines, support groups, and educational resources to address stigma and promote mental health awareness (SADAG,2022)[92]. More detailed discussions on the efforts of NGOs and NPOs in reducing stigma and enhancing mental health service delivery are provided in the service delivery section of this report.

Stressful life events and social isolation

Stressful life events, such as death in one's family, exposure to abuse, diagnosis of life-altering illnesses, and job loss, profoundly affect the mental well-being of individuals. The Covid-19 pandemic has emerged as a particularly impactful event, exacerbating existing mental health challenges, and creating new ones. Research indicates a notable increase in rates of depression, anxiety, and post-traumatic stress disorder (PTSD) since the onset of the pandemic (WHO, 2022)[93]. Contributing factors include heightened fear and uncertainty regarding infection, socioeconomic hardships resulting from lockdowns and economic disruptions, social isolation due to movement restrictions, and the burdens faced by frontline workers. Additional research on whether these mental health concerns continued post-Covid would be useful to understand mental illness diagnosis rather than experiences of a stressful life event.

The pandemic has also magnified existing societal inequalities, disproportionately impacting vulnerable populations such as children, adolescents, individuals with pre-existing mental health conditions and marginalised communities. A paper by Hunt et. al (2021)[58] highlights the impact Covid-19 had on unemployment rates and increased levels of poverty in South Africa. The individuals who lost their employment because of Covid-19 were found to be significantly more likely to report experiencing depressive symptoms than the general population. Post the Covid-19 pandemic, net employment was down 1.4 million jobs relative to the pre-pandemic levels, and job losses have been nonconcentrated amongst the most vulnerable individuals (Köhler et. al, 2021)[94]. Covid-19 has therefore resulted in a loss of financial security and potentially mental health for many individuals. Covid-19 was found to be especially impactful on the healthcare sector, and in the mental wellbeing of healthcare workers as explained in the case study below.

[91] Gumede, W. (2021). 'Untreated mental illnesses impact SA's economy, social and family stability'. Available at: https://www.wits.ac.za/news/latest-news/opinion/2021/2021-10/untreated-mental-illnesses-impact-sas-economy-social-and-family-stability.html
[92] SADAG. (2022). Healthcare workers fear mental health stigma. Available at: healthcare-workers-fear-mental-health-stigma.pdf (sadag.org)
[93] WHO. (2022). 'COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide'. Available at: https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide
[94] Köhler, T., Bhorat, H., Hill, R. and Stanwix, B. (2021). COVID-19 and the labour market: Estimating the employment effects of South Africa's national lockdown. Development Policy Research Unit Working Paper 202107. DPRU, University of Cape Town.

Case Study: Mental Health of healthcare workers by Cook et. al (2021)[95,96]

During Covid-19 the mental health of healthcare workers (HCWs) was more relevant than ever before as workers deemed vital to the functioning of the economy still reported to work, while other employees were restricted to working from home. Besides needing to report in to work, healthcare workers were significantly under resourced and many experienced burn-out as hospitals filled up with Covid-19 patients (Cook et. al, 2021)[95] . Risk factors exposing health care workers to mental health issues included the mental health burden associated with Covid-19 from a health perspective, such as working with a poor understanding of the virus and new and frequently changing protocols, increased use of personal protective equipment (PPE), prolonged working hours and inadequate hospital equipment. While HCWs are seen to experience a great amount of stress at work, they also faced social isolation and quarantine measures at home, like the rest of South Africa. Some healthcare workers even chose to separate themselves from their families to protect them and prevent the spread of the virus experiencing stigma, loneliness, and a lack of trust. This results in low levels of social support which is seen to negatively impact the performance of HCWs (Watermeyer, Madonsela and Beukes, 2023)[96] .

Healthcare workers also experienced stress related to possible loss of income as many workers contracted Covid-19 would be asked to stay home. Poor mental and physical health was also cited as a stressor which was feared to lead to poor work performance, and poor health overall. Health workers also experienced anxiety around adjusting to working during Covid-19, with learning to work with new protocols, uncertainty on day-to-day work, increased workloads and using online therapy instead of the as-is in person therapy. It was also noted that while many health care workers made use of various support structures at home/communities and at work, many noted that they had no support structures available.

The study by Watermeyer et. al, (2023) found elevated psychiatric morbidity among hospital staff. Healthcare-related stress during lockdown Levels 3 to 1 was strongly associated with worse symptoms of depression, anxiety, and post-traumatic stress disorder. The study also found salient experiences of fear and Covid-19 infection risk, acute resource shortages, and long-term healthcare infrastructural constraints. The prevalence rates of probable psychiatric disorders across the psychiatric health workers in the sample were: 24% for depression, 20% for anxiety, 13% for post-traumatic stress disorder (PTSD), and 4% for bipolar disorder. Nearly all study participants expressed extreme and deep-seated fear of becoming infected with Covid-19. These concerns were driven by unsafe working conditions, the fear of infecting patients and family members, and the fear of death. PPE shortage was among the greatest sources of distress for hospital staff. At the onset of the pandemic, psychiatric hospitals lacked many of the essential items necessary for an appropriate Covid-19 response, as these items were not required for psychiatric care, including PPE, oxygen concentrators, and ventilators. Some hospital managers were forced to ration PPE until stock became available, and in the meantime, required wards to motivate for PPE and selectively sourced PPE to high-risk wards. This led to

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[95] Cook, L.J., Hassem, T., Laher, S., Variava, T., & Schutte, E. (2021). Mental health experiences of healthcare professionals during COVID-19. SA Journal of Industrial Psychology/SA Tydskrif vir Bedryfsielkunde, 47(0), a1865. https://doi.org/10.4102/sajip.v47i0.1865

[96] Watermeyer, J., Madonsela, S. & Beukes, J., 2023, 'The mental health and wellbeing of healthcare workers during COVID-19 in South Africa', Health SA Gesondheid 28(0), a2159. https://doi. org/10.4102/hsag. v28i0.2159

extreme frustration and other negative feelings and experiences (unfairness, unhappiness, moral injury) among healthcare workers.

Additionally, the sharp rise in symptomatic and Covid-19-positive cases during the peak of the first wave resulted in numerous workers having to quarantine or take sick leave, leaving many wards short-staffed. Staff shortages affected nearly every level of the hospital workforce including – nurses, safety officers, medical officers, registrars, and consultants – and were strongly associated with burnout. Healthcare workers were frequently allocated to different wards and expected to provide services that they were not adequately trained to deliver. The redeployment of staff to new units and mandatory testing procedures led to adverse reactions amongst staff. The limited availability of space to manage Covid-19 patients also posed massive issues for healthcare employees.

THEME 2 UNDERSTANDING MENTAL HEALTH SERVICE PROVISIONING IN SOUTH AFRICA

OBJECTIVES FOR THEME 2:

Provide an overview of available mental health services across different types of public and private providers such as government (across all healthcare levels from primary to tertiary care), non-governmental organisations (NGOs) and community-based organisations (CBOs). Analyse funding distribution and assess geographical accessibility, including provincial and urban-rural divides. Evaluate the integration of mental health services within primary healthcare settings, highlighting challenges and successes encountered. Develop 2-3 case studies to contextualise what opportunities exist for public and private collaborations in the mental healthcare space as well as a case study on the Life Esidimeni tragedy.

The information presented in this theme will comprise a literature review of available information on service delivery in South Africa, as well as insights from stakeholder interviews.

The prevalence and incidence of mental health conditions are directly influenced by the availability, accessibility, and affordability of mental health services. In South Africa, systemic issues within the healthcare system significantly impact the population's mental health, necessitating urgent attention. This section will detail mental health service providers, the range of services they offer, their geographical distribution, delivery modalities, personnel involved, funding sources, and allocation strategies.

OVERVIEW AND CONTEXT

The South African healthcare system is split into a public and private health system which exist in parallel. Most of the population (71%) accesses health care through the public health system (Rensburg, 2021)[97]. The National Department of Health holds responsibility for overseeing the delivery of health services, with the Provincial Departments of Health managing implementation within their respective province.

The health system in South Africa is structured into primary, secondary, and tertiary levels of care (National Department of Health, 2020)[98]. The diagram below provides an overview of the healthcare system.

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[97] Rensburg, R. (2021). 'Healthcare in South Africa: how inequity is contributing to inefficiency', Wits News, 7 July. Available at:
https://www.wits.ac.za/news/latest-news/opinion/2021/2021-07/healthcare-in-south-africa-how-inequity-is-contributing-to-inefficiency.html
[98] National Department of Health. *Referral Policy for South African Health Services and Referral Implementation Guidelines*; National Department of Health: Pretoria, South Africa, 2020. Available at: https://knowledgehub.health.gov.za/system/files/elibdownloads/2023-04/National%2520Referral%2520Policy%2520for%2520SA%2520Health%2520Services%2520and%2520Implementation%2520Guidelines%2520Aug%2520202 0.pdf

Figure 12: Diagrammatic representation of the levels of healthcare available in South Africa[98]
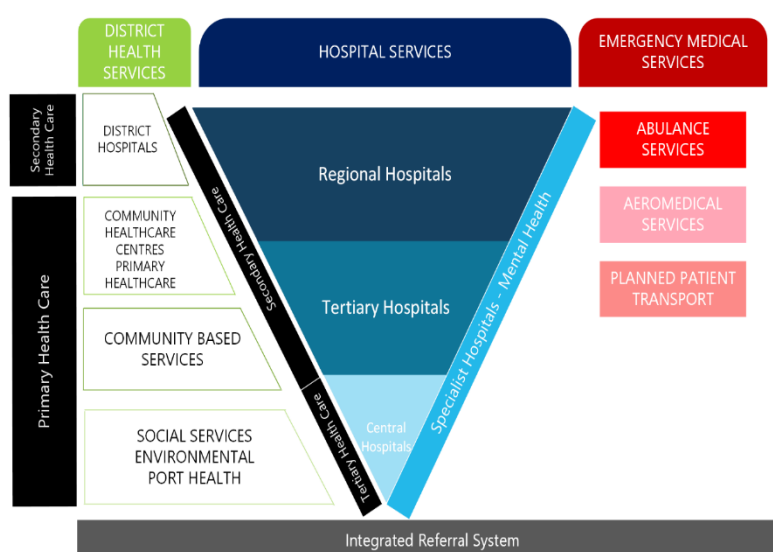
Primary care facilities serve as the initial point of contact for individuals seeking healthcare services. District hospitals constitute the second level of care, offering more specialised services, while tertiary care, is provided by regional to specialised hospitals, delivering highly specialised medical interventions (National Department of Health,2020)[98]. The primary level of care covers services from community-based services to primary healthcare clinics. Secondary healthcare facilities mainly manage severe mental disorders like schizophrenia and bipolar mood disorder as outpatient cases, from initial patient intake to follow-up care for chronic medication. However, these clinics often lack sufficient staffing and access to medications, hindering comprehensive treatment management (Sopitshi and Niekerk, 2021)[99].

District health services' four components are illustrated in Figure 12. At lower care levels, emphasis is on social, environmental, and port health services to promote public health. Moving up, community-based services provide sustained care within communities, aiding patients with chronic conditions, disabilities, and elderly care, addressing holistic health needs. District services are further extended through primary healthcare clinics (PHCs) and community health centres (CHCs), offering various types of healthcare services, including promotive, preventive, curative, rehabilitative, palliative, and community-based mental health services. If care is unavailable, patients are referred to higher levels of healthcare (National Department of Health,2020)[98].

Community based services encompass outpatient and emergency care, residential care, and day care, as seen in Figure 13 (Flisher et. al, 2003)[100]. These services are provided through local community centres, NGO facilities, religious institutions, schools, and other support groups. For example, ward-based outreach PHC teams (WBOTs) and integrated school health teams offer health education, screening, disease prevention, adherence support, and de-hospitalised care, including chronic and sub-acute care, palliative care, mental healthcare, and

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[99] Sopitshi, A., & Van Niekerk, L. (n.d.). County Profile: South Africa. https://healthmarketinnovations.org/sites/default/files/Final_Country%20Profile_South%20Africa_CHMI.pdf (link is external and opens in a new window)
[100] Flisher AJ, Jansen S, Lund C et al. (2003) Norms for community mental health services in South Africa. Cape Town, Department of Psychiatry and Mental Health, University of Cape Town.

home-based care at community level (National Department of Health,2020)[98]. Additionally, district clinical specialist teams provide mentoring, supervision, clinical support, and outreach services for primary healthcare clinics. NGOs focus on providing care for individuals with intellectual disabilities and chronic care is needed to provide service capacity to the health system (National Department of Health,2020)[98].

Figure 13: Types of Community Based Mental Health Services[98]
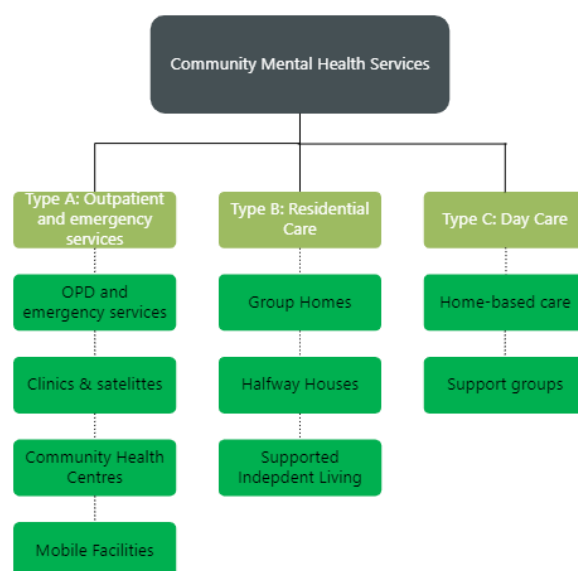
District hospitals serves as the highest level of healthcare support within the district health system, offering comprehensive mental health services, including screening services, 72-hour observations as well as psychosocial assessments and treatment (National Department of Health,2020)[98]. Care is predominantly provided by doctors and primary health care nurses, with medication management, including prescribing within the regulations outlined by the Medicines Act. Referrals to higher levels of care are coordinated for patients in need of specialised treatment. Regional and provincial tertiary hospitals offer specialised psychiatric care for complex cases, and specialised psychiatric hospitals provide intensive treatment for severe and persistent mental illness (National Department of Health,2020)[98].

Lastly, Emergency Medical Services (EMS) including ambulance and aeromedical service, facilitate transport to referral hospitals for patients, including those with mental health needs, ensuring they reach their appointments and access appropriate care (National Department of Health,2020)[98].

PRIVATE MENTAL HEALTH IN SOUTH AFRICA

In the private sector, 41 hospitals provide inpatient mental health services with a total of 755 beds (Kagee et. al, 2022, p.178)[101]. Prescribed Minimum Benefits (PMBs), which cover 270 conditions include two psychiatric conditions: unipolar and bipolar depression, and schizophrenia[101]. PMBs also encompass conditions such as epilepsy, sexual abuse/rape counselling and HIV testing. Most treatment occur in hospitals, with schizophrenia

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[101] Kagee, A., Docrat, S., Freeman, M., Lund, C., Phakathi, S., Shiba, D., and Thom, R. (2022). 'Chapter 10: Mental Health', in *The South African Health Reforms 2015-2020: The Road Ahead.* SAMJ: Pretoria*, pp. 178-200.

treatment limited to inpatient care only. This structure promotes hospital-centred and costly care, necessitating co-payment from members. Depression claims ranked amongst the top 10 expenditures for Discovery Health members from 2019 to 2020 (Kagee et. al, 2022, p.178)[101]. The private sector reports the availability of 4.98 psychiatrists per 100,00 population compared to less than 1 per 100,000 in the public sector (Kagee et. al, 2022, p.178)[101].

FACILITY LEVELS AND SERVICES

This section will provide an overview of mental health facilities at different levels of care and the range of mental health service provided at each level.

Types of mental health services

Table 2 below outlines levels of care for mental disorders, from primary to specialised. Community-based services use collaborative care, while severe cases are referred to specialised hospitals for diagnosis and treatment. Staffing varies and facilities lacking sufficient staff and access to medication may refer patients needing medication to high care levels (National Department of Health, 2020)[98].

Table 2: Summary of Mental Health Care Service Providers in the Public Healthcare System[102,100]

FACILITY TYPE	SERVICES OFFERED	STAFF AT FACILITY	NUMBER OF MENTAL HEALTH BEDS AVAILABLE NATIONALLY
Community Based Services (e.g., ward-based outreach teams [WBOTs], integrated school programmes, NGO/NPO/CBO services) & Community Health Centres	Health education, health promotion, screening, prevention of disease, adherence support and de-hospitalised care comprising chronic care, collection of repeat scripts, sub-acute care, palliative care, mental healthcare, and home-based care. Community health workers screen at-risk individuals, while existing mental health care users are referred to Ward-Based Outreach Teams for assessment, intervention, and adherence support.	Community health workers, Ward based outreach team members, counsellors, mentors, and other lay community workers.	Non applicable for community-based services
PHC clinics	Detects, diagnoses, and treats common mental health conditions, and organises the referral of more complicated mental health problems to more appropriate levels of mental health care (Western Cape Department of Health,	General practitioners and General clinical nurse practitioners providing PHC services.	Non applicable for clinics

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[102] Academy of Science of South Africa (ASSAf), (2021). Provider core competencies for improved Mental health care of the nation. [Available online] DOI http://dx.doi.org/10.17159/assaf.2019/0067.

FACILITY TYPE	SERVICES OFFERED	STAFF AT FACILITY	NUMBER OF MENTAL HEALTH BEDS AVAILABLE NATIONALLY
	n.d.)[103] Supports the collection of repeat scripts.		
District Hospitals	Designated mental health units attached to district hospitals provide further care, treatment and rehabilitation of involuntary mental health care users after the 72-hrs assessment has been concluded (for involuntarily patients). These facilities will also determine the need for further care, treatment and rehabilitation. Provides follow-on medication and repeat scripts for patients. Accommodate voluntary or assisted mental health care users (MHCUs) for acute admission.	General practitioners and General clinical nurse practitioners providing PHC services. Nursing professionals with experience in mental health, a medical practitioner with experience in psychiatry (preferably a family physician with a Diploma in Mental Health), a psychologist, as well as representatives of the hospital social work and occupational therapy departments.	246
Regional Hospitals	Designated mental health units attached to regional hospitals provide further care, treatment and rehabilitation of involuntary mental health care users after the 72-hrs assessment has been concluded (for involuntarily admitted patients). These facilities also determine the need for further care, treatment and rehabilitation. Provides follow-on medication and repeat scripts for patients. Accommodate voluntary or assisted MHCUs for acute admission.	A range of professionals including Psychiatrists, Clinical Psychologists, Nurses, Social Workers, Occupational Therapists, and Dieticians.	507
Tertiary / Provincial Hospitals	Diagnoses and treats severe mental health conditions with referral for more complicated cases. Provision of psychotropic medication.	A range of professionals including Psychiatrists, Clinical Psychologists, Nurses, Social Workers, Occupational Therapists, and Dieticians.	263
Central Hospitals	Diagnoses and treats severe mental health conditions with referral for more complicated cases. Provision of psychotropic medication. Provision of sub-specialist services, such as forensic psychiatry, child and adolescent, neuropsychiatry, geriatric psychiatry, and consultation-liaison psychiatric	A range of professionals including Psychiatrists, Clinical Psychologists, Nurses, Social Workers, Occupational Therapists, and Dieticians.	423

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[103] Western Cape Department of Health. (n.d.). Mental Health Primary Healthcare (PHC) Services. Available at:
https://www.westerncape.gov.za/service/mental-health-primary-healthcare-phc-services#:~:text=Description%3A,levels%20of%20mental%20health%20care.

FACILITY TYPE	SERVICES OFFERED	STAFF AT FACILITY	NUMBER OF MENTAL HEALTH BEDS AVAILABLE NATIONALLY
	services (National Mental Health Framework and Strategic Plan, 2023-2030)[2] The facility allocates wards for specific demographics with mental health issues: **Eating disorders & adolescent unit.** Provides pharmacotherapy, dietary counselling & nutritional support, nurse therapy, CBT-E psychotherapy (a specialised form of cognitive behaviour therapy for the treatment of eating disorders), group psychotherapy, occupational therapy, parental counselling, or family support where relevant, and social work intervention if indicated. School-going patients on the higher stages of the programme are required to attend schools specified by the facility. **Psychotherapy unit.** Provides pharmacotherapy as well as various individual and group therapeutic interventions according to their needs. Electroconvulsive Therapy is also available for in- and outpatients who require it. Child unit includes in-patients attending schools prescribed by the facility. Outpatient services include individual, group and family therapy (Gauteng Mental Health Strategy and Action Plan 2019-203)[104]		
Specialised Hospitals	Delivers care equivalent to central hospitals and includes a forensic psychiatry unit for court-referred psychiatric assessments and rehabilitation of mentally disordered offenders (National Department of Health, 2020)[98]	A range of professionals including Psychiatrists, Clinical Psychologists, Nurses, Social Workers, Occupational Therapists, and Dieticians.	10 725

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[104] Gauteng Mental Health Strategy and Action Plan 2019 – 2030

FACILITY TYPE	SERVICES OFFERED	STAFF AT FACILITY	NUMBER OF MENTAL HEALTH BEDS AVAILABLE NATIONALLY
EMS services	Arrivals and departures transported to hospitals via SAPs or EMS	EMS general staff.	N/A

The Mental Health Atlas for South Africa (2020)[14] reports 26.74 mental hospital beds per 100,000 people (15 658 beds), and 6.99 (4 093 beds) general hospital psychiatric beds per 100,000 people. Additionally, there were 17.99 community residential beds (10 535) and 11.97 child and adolescent specific inpatient beds per 100,000 people (6 968 beds) according to the Mental Health Atlas report. However, these figures significantly differ from the data collected in the 2019 Mental Health Investment Case. This variance in mental health bed numbers can be attributed to differences in data collection methods, timeframes, variation in criteria for classifying mental health beds, and accuracy of reporting. Therefore, we cannot conclusively determine the number of mental health beds available based solely on these data sets. Further exploration involving key stakeholders at the provincial level will be necessary to obtain a more comprehensive understanding of mental health bed situation in South Africa.

72-hour observations and hospitalisations

District and regional hospitals serve as essential components of healthcare provision, including mental health service, within communities, serving as the initial point of contact for individuals requiring hospital-based care. One of the essential mental health services provided by these hospitals is the 72-hour admission and observation of involuntarily admitted mental healthcare service users (DOH, 2012)[105], as mandated by the Mental Health Care Act (2002) and in accordance with international human rights standards (Lund et. al,2008)[106]. The ability of the facility to provide this service depends on the severity of the patient presenting and whether the facility has the appropriate human resources available to assist this patient. Across all provinces, district and regional hospital have designated mental health units which are nominated to be listed as providing 72-hour observation to involuntary patients[13]. Using information available for seven of the nine provinces, the table below shows that every district in each province has 72-hour assessment facilities available.[107,108,109,110,111,112,113]

[105] South Africa. Department of Health. (2002). Mental Health Care Act (South Africa). Pretoria: Volume 449: 24024

[106] Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, & Flisher AJ. (2008). Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 Country report. Cape Town: Mental Health and Poverty Project.

[107] Eastern Cape Department of Health. (2024/2025). 'Listed Hospitals for the 72-hour assessment of mental health users 2024/2025'

[108] Gauteng Department of Health. (n.d.). 'List of health Establishments/Hospitals in Gauteng Province Listed to Render 72 Hours Assessment in Terms of Regulation 12 of the Mental Health Care Act 17 of 2002 as Amended'

[109] KwaZulu-Natal Department of Health. (2023/2024). 'Annual Listing (2023/2024) of the Health Establishments in Each District in the Province that provides 72-hours Assessment as contemplated in Section 34 of the Mental Health Care Act, 2022'

[110] Limpopo Department of Health. (2023/2024). 'List of 72hrs Assessment Facilities: Limpopo 2023/2024'

[111] Mpumalanga Department of Health. (2023/2024). 'List of Health Establishments Providing 72-hour Mental Health Assessment Services to Involuntary Mental Health Care Users in the Province'

[112] Northern Cape Department of Health. (n.d.). 'State Health Facilities Rendering 72hrs – Mental Health Assessment'

[113] Northwest Department of Health. (2021). 'National update of mental health facilities 2021'

Table 3: Number of 72-hour facilities across each province[107,108,109,110,111,112,113]

PROVINCE	NO. OF FACILITIES PROVIDING 72HR ASSESSMENTS	TYPE OF FACILITY	NO. OF DISTRICTS PROVIDING 72-HR ASSESSMENTS	PERCENTAGE OF DISTRICTS WITH ACCESS TO 72-HR ASSESSMENTS
Eastern Cape	62	District & Regional Hospitals (56) Psychiatric Hospitals (3) Mental Health Units (3)	8	100%
Gauteng	17	District & Regional Hospitals (17)	5	100%
KwaZulu-Natal	55	District & Regional Hospitals (48) Specialised Hospitals (4) Tertiary facilities (1) Psychiatric Hospital (2)	10	100%
Limpopo	37	District & Regional Hospitals (37)	5	100%
Mpumalanga	27	District & Regional Hospitals (27)	3	100%
Northern Cape	13	District & Regional Hospitals (13)	5	100%
Northwest	6	District & Regional Hospitals (3) Tertiary facility (1) Psychiatric Hospital (2)	4	100%

In an interview with a NDoH Stakeholder[13], it was highlighted that if a patient at risk of harming themselves or others presents at a facility not designated as one of the nominated 72-hour facilities, the facility may still offer support and observation based on the availability of appropriate human resources. Additionally, the facility may provide a referral to the patient if a higher level of care is deemed necessary.

Patients presenting with acute, severe symptoms, including suicidal behaviour, are treated as an emergency, and are admitted to district or other general hospitals designated for stabilisation and observation for 72 hours. During the 72-hour period, it is established whether onward referral for more specialised care, treatment and rehabilitation is required (Emsley et. al,2013)[114]. In severe cases, stabilising patient in a hospital setting may precede outpatient treatments until symptoms improve, at which point they can transition to outpatient care.

In a journal article published in 2008, the author highlighted challenges in implementing 72-hour observations at district hospitals, including over-sedation of mental health care users, difficulty managing agitated patients, and inappropriate medication use. These issues stemmed from infrastructural and functional deficiencies, such as inadequate facilities and skills, poor understanding of regulations, and a lack of proper protocols and

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[114] Emsley, R., Flisher,A.J., Grobler,G., Seedat,S., and Szabo, C.P. (2013). 'The South African Society of Psychiatrists (SASOP) Treatment Guidelines for Psychiatric Disorders'. Available at: https://sajp.org.za/index.php/sajp/article/view/942/552

awareness. Additionally, unclear roles of law enforcement and emergency services complicated effective care delivery (Burns, 2008)[115].

FACILITIES PROVIDING MENTAL HEALTH SERVICES

Masiviwe[10], supported by PEPFAR and by the Foundation for Professional Development (FPD), includes the development of a mental health map detailing public and private mental health facilities across South Africa's provinces. This map categorises facilities by service provider type (NGO, CBO, or government) and indicates whether services are provided free of charge.

The District Health Information System (DHIS)[116] is a national data system which provides details on facilities across all nine provinces. This includes the location (district and if urban or rural), coordinates, opening and closing (where applicable) dates, and the organisational unit type. For analytical purposes, the DHIS data, which includes 60 different facility types was condensed into 9 facility types. The nine types mapped include:

1. Clinic
2. Community Centre
3. District Hospital
4. EHS
5. Outreach
6. Rehabilitation
7. Hospital
8. Private
9. Specialised Psychiatric Hospital

The mapping of 60 facility types down to 9 facility types can be seen in Appendix B. Based on mapped facility data from the District Health Information System (2023) as seen in Figure 14, there are currently 3 788 clinics, 252 district hospitals, 76 regional, provincial, and national hospitals and 24 specialised psychiatric hospitals. This data set also includes 358 community-based centres which may provide mental health services.

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[115] Burns, J K. (2008). Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. *SAMJ: South African Medical Journal*, *98*(1), 46-49. Retrieved February 14, 2024, from http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742008000100023&lng=en&tlng=en.
[116] District Health Information System. (2023). Available at: dd.dhmis.org/orgunits.html?file=NIDS Integrated&source=nids&ver=1015

Figure 14: Number of public healthcare facilities in South Africa in 2023 as per District Health Information System data[116]
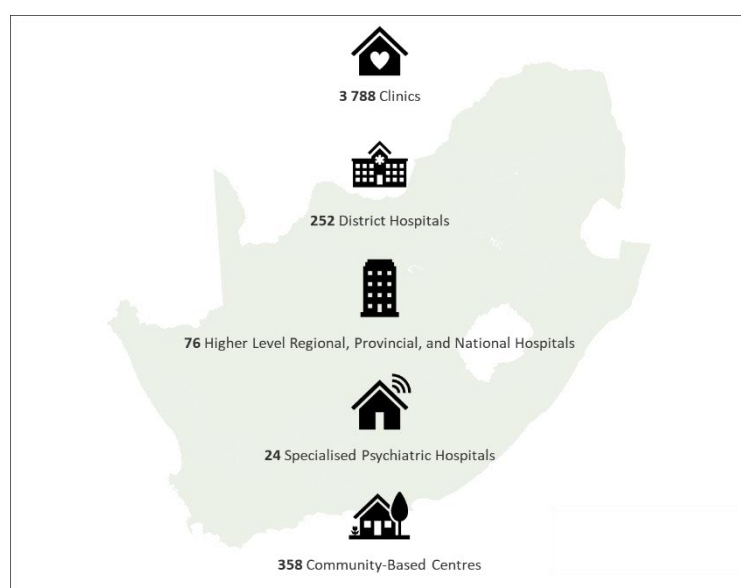
Looking at additional sources, Sorsdahl et. al (2023)[12], there are 3 472 primary healthcare clinics, 254 districts hospitals and 75 higher level regional, provincial, and national hospitals and 24 specialist psychiatric hospitals. These hospitals are unevenly distributed among provinces with one province, Mpumalanga, having no specialised psychiatric hospital and KwaZulu-Natal and the Western Cape having as many as five. Data from this study indicate that there are 355 licensed community-based mental health facilities. Of these, 261 are residential and 94 are day care facilities (Sorsdhal et. al, 2023)[12]. The findings from the DHIS data align closely with those of (Sorsdhal et. al, 2023)[12]. However, it's important to note that the author of the study does not reference the date source used in their study.

Comparatively, data from the WHO Mental Health Atlas for 2020[14] in South Africa shows 89 mental health hospitals (compared to 76 and 75 noted above), 259 community residential facilities, and 80 inpatient facilities for children and adolescents. For outpatient care there are 4 939 community based/non-hospital mental health outpatient facilities, of which 652 are for children and adolescents specifically. The total number of community based mental health facilities is reported as 5 198, encompassing centres, day treatment facilities and residential/rehabilitation facilities.

With the limited DHIS data available, detailed insights were obtained regarding the distribution and types of healthcare facilities across South Africa's provinces. It is imperative to recognise that the DHIS data, may not offer a complete representation of mental health service provision across all facilities, especially at clinic level. The limited number of facilities (426), providing mental health services including government (primary, secondary, and tertiary facilities), NGOs and CBOs from Masiviwe[10] data are also not a true reflection. While legislature indicates that mental health care is provided across all public healthcare facilities albeit at different levels of care, it is not possible to draw conclusions regarding the actual number of facilities providing mental health services and other related aspects based solely on the available data.

Figure 15 below illustrates the distribution of facilities per province for both public and private facilities, with darker-coloured provinces indicating a higher availability of facilities compared to lighter-coloured provinces based on data extracted from the DHIS as of 2023.

Figure 15: Heat map showing the distribution of facilities per provinces (High density - dark green, low density - light green)[116]
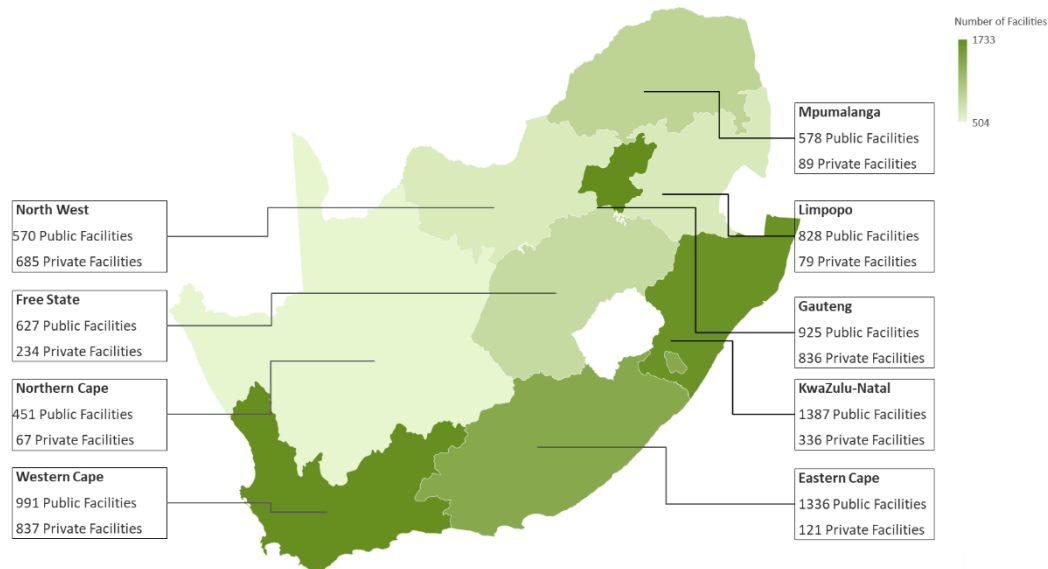
Based on the DHIS data and our mapping methodology (inclusive of nine facility types) in South Africa there are 8 597 facilities, split between 6 473 public (75%) and 2 124 private (25%) where we have excluded facilities such as pharmacies, general and nurse practitioners, labs, universities, stock distribution points, malaria units, specialists, depots, obstetrics units, step down facilities, hospices and other non-mental health specialised facilities.

Provinces such as the Mpumalanga, Northwest and Northern Cape have fewer facilities available when compared to provinces such as the Western Cape, Gauteng, and KwaZulu-Natal. This distribution may be attributed to the larger budgets or higher population numbers typically found in these provinces.

The analysis of facility type was limited to public sector facilities.

Figure 16: Total number of facilities by facility type[116]

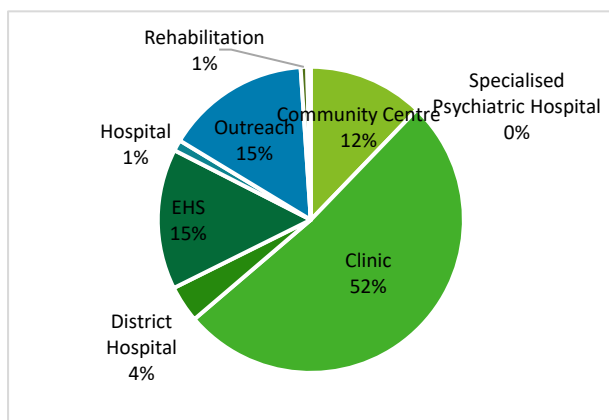Figure 16 shows that nationally the distribution of public facilities are as follows, clinics make up 52%, outreach programmes 15%, emergency health services 15% and district hospitals 4%. Other public facilities include regional, provincial, and national hospitals making up 1% of all public facilities as well as rehabilitation centres also making up 1% and very few specialised psychiatric hospitals (24) facilities.

Figure 17: Distribution of public healthcare facilities across provinces[116]
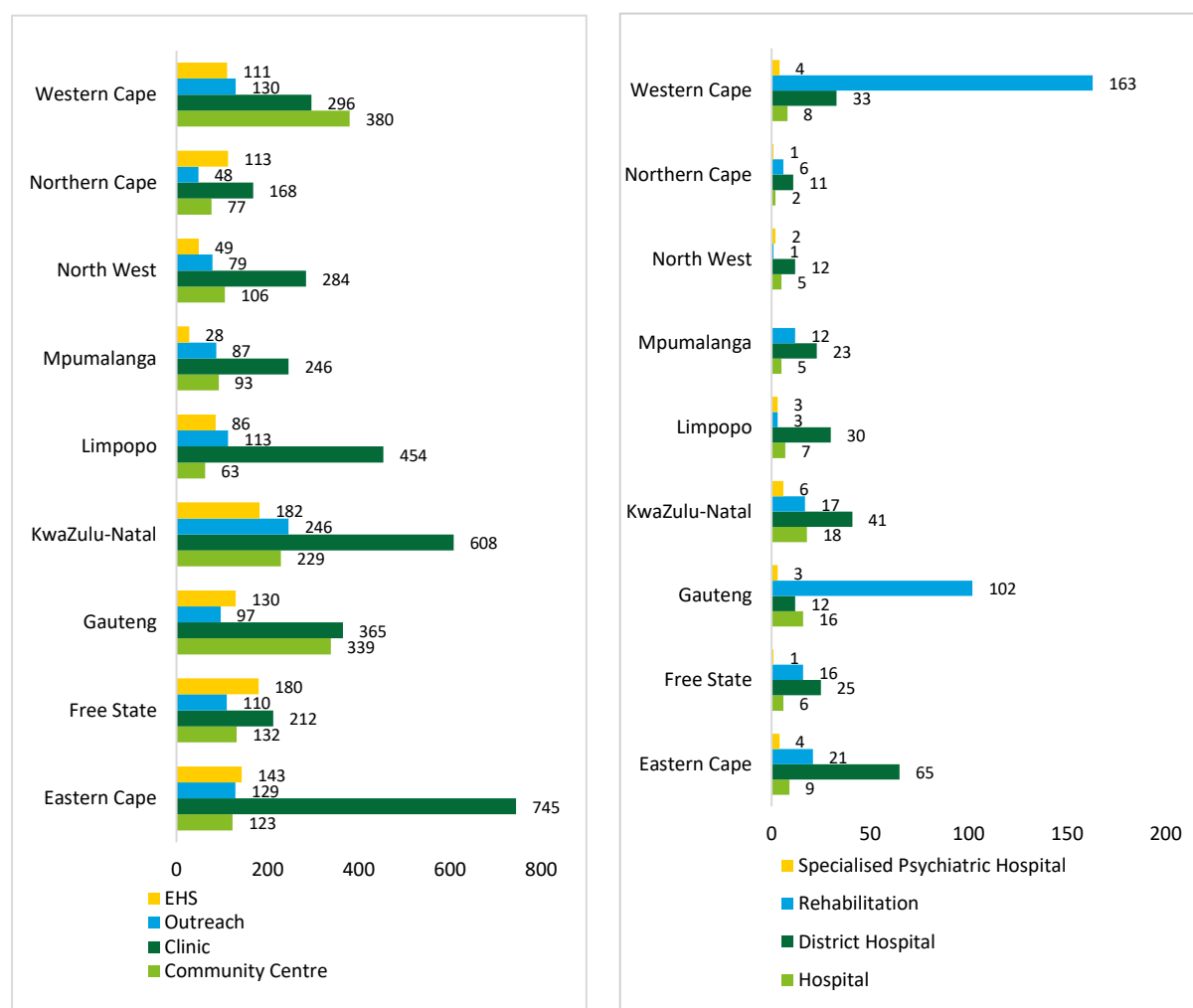
In Figure 17, it becomes evident that certain provinces have a significant variance in the availability of healthcare facilities. Provinces like KwaZulu-Natal (608) and Eastern Cape (745) have a higher number of clinics compared to provinces such as the Northern Cape (168) and Free State (212), which have considerably fewer clinics available. Similarly, provinces like Mpumalanga (93), Northern Cape (77), and Limpopo (63) have a limited number of health and community centres compared to Gauteng (339) and the Western Cape (380). Emergency Health Services (EHS) are generally scarce across provinces, except for KwaZulu-Natal (182) and the Free State (180), which report a higher number of EHS. When considering outreach care, KwaZulu-Natal (246) leads with many outreach facilities, followed by the Western Cape (130). Conversely, provinces like Northern Cape (48), Northwest (79), and Mpumalanga (87) have few outreach facilities available, which is concerning given their remote and rural populations.

With regards to rehabilitation, the Western Cape (163) and Gauteng (102) have numerous facilities, whereas other provinces report fewer. Notably, Mpumalanga lacks specialised mental health facilities, while provinces like Western Cape and Eastern Cape each report four. Hospitals, refer to regional, provincial, and national hospitals. Provinces such as Eastern Cape (9), Gauteng (16) and KwaZulu-Natal (18) have much more of these

hospitals when compared to provinces such as Northern Cape (2), Northwest (5) and Mpumalanga (5). District hospitals are scarce in the Northern Cape (11), Northwest (12) and Gauteng (12) with much more district hospitals in province such as KwaZulu-Natal (41) and Eastern Cape (65).

These findings highlight the need for targeted interventions and resource allocation to address disparities in healthcare provision, particularly in underserved regions with limited access to essential services.

Figure 18: Location of facilities (urban vs rural)[116]
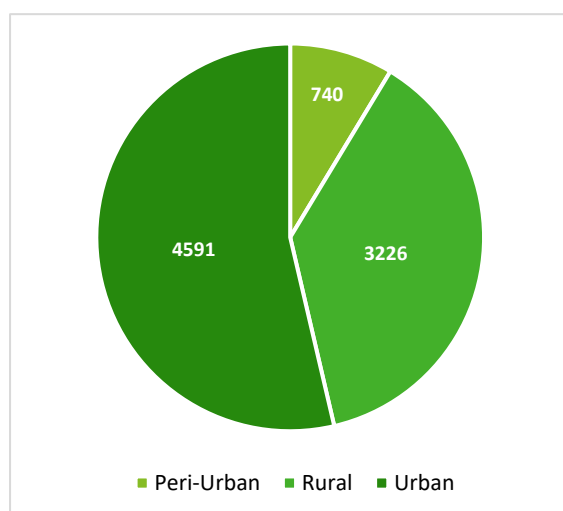
The DHIS data shows that there are 4 591 facilities located in urban areas (54%), 3 226 in rural areas (38%) and 740 in peri-urban areas (8%), with some facilities not having a location listed. When comparing this to the data on the 426 facilities from Masiviwe (only including facilities rendering mental health services), there were 363 (85%) of facilities located in urban areas and 63 (15%) located in rural areas. If the Masiviwe dataset were more comprehensive, it could be inferred that individuals in urban areas have greater access to mental health services compared to those in rural areas.

When assessing the distribution of mental health facilities by need, one of the key determinants explained in Theme 1 was the relationship between unemployment, poverty and income levels influence an individual's mental health. Individuals with low-income levels or who are unemployed are predisposed to experiencing mental health issues and remaining in the vicious cycle of poverty and mental health issues. Figure 18 provides insights into provinces with higher unemployment rates and their access to mental health services.

The assumption was made that mental health care services are provided at no cost at the public healthcare facilities as stated in the Mental Health Atlas 2020[14], while the private sector facilities are considered to provide service at a charge. Unemployment rates were obtained from StatsSA (2023)[117]. The Northwest stands out with the highest unemployment rate across all provinces and is also one of the provinces with the fewest mental health care facilities available. This requires investigation to understand whether the Northwest has enough facilities to service their expected depressed population which will be unpacked later in the report.

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[117] StatsSA. (2023). Unemployment Rates. Available at: https://www.gov.za/news/media-statements/statistics-south-africa-quarterly-labour-force-survey-quarter-three-2023-14#:~:text=The%20official%20unemployment%20rate%20was,the%20second%20quarter%20of%202023.

Figure 19: Number of facilities per province by unemployment rate[116,117]
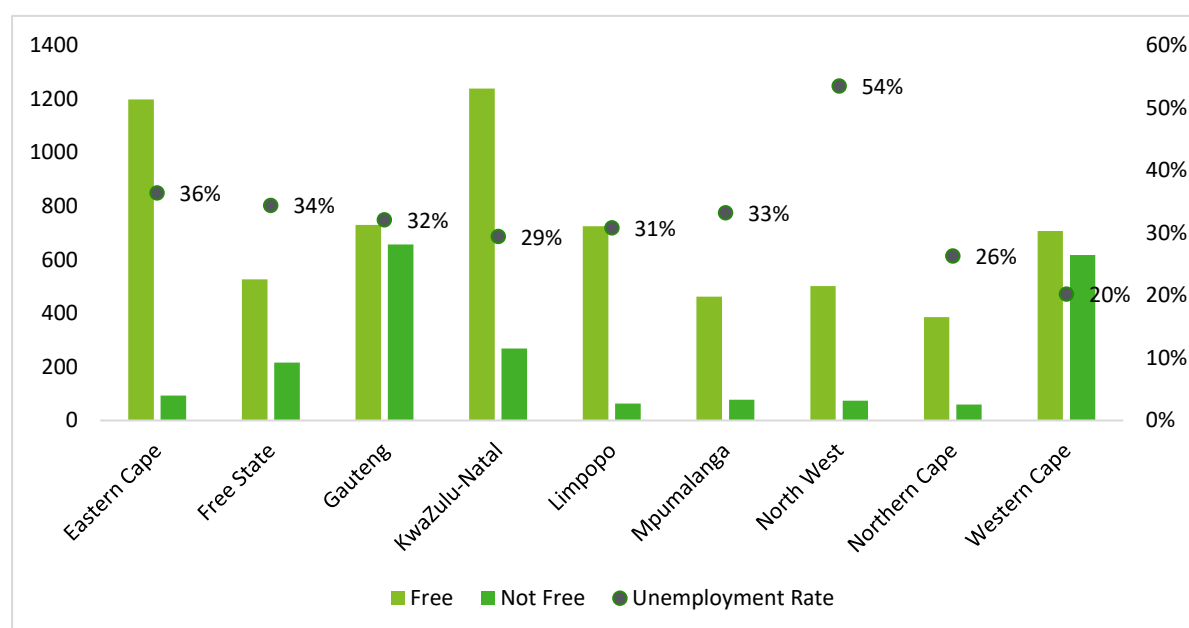
Using prevalence data from the Wits Probable Depression Study (2022)[6] and DHIS facility data[116] the map below was developed to show whether provinces with higher incidence of depression or anxiety symptoms have access to the necessary service providers to meet this need.

Graph A provides the prevalence of probable depression estimates as per the Wits probable depression study (Craig et. al, 2022)[6.] Graph B provides a ranking across provinces based on the number of facilities across all nine provinces. KwaZulu-Natal is ranked highest (9) as it is the province with the greatest number of facilities compared to the Northern Cape (ranked 1) with the fewest facilities. Graph C represents a ratio per 100,000 people to be serviced per facility in each province. To determine the number of people to be serviced by each facility, the probable depression rates were applied to the total population per province derived from StatsSA (2022) data[118], to determine the expected depressed population. The number was then divided by the number of facilities per province to get the number of people that would be serviced per facility in each province. This number was then divided by 100,000 to get a ratio which is easier to interpret.

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[118] StatSA. (2022). 'Population Census'. Available at: Provinces_at_a_Glance.pdf (statssa.gov.za)

Figure 20: Map of prevalence overlayed with number of all facilities[6,10,116,118]

Graph A — Distribution of probable depression across provinces based on the Wits 2022 study

Graph B — Number of facilities ranked by province (more facilities refers to a higher ranking across provinces)

Graph C — Number of people serviced per facility per 100,000 people
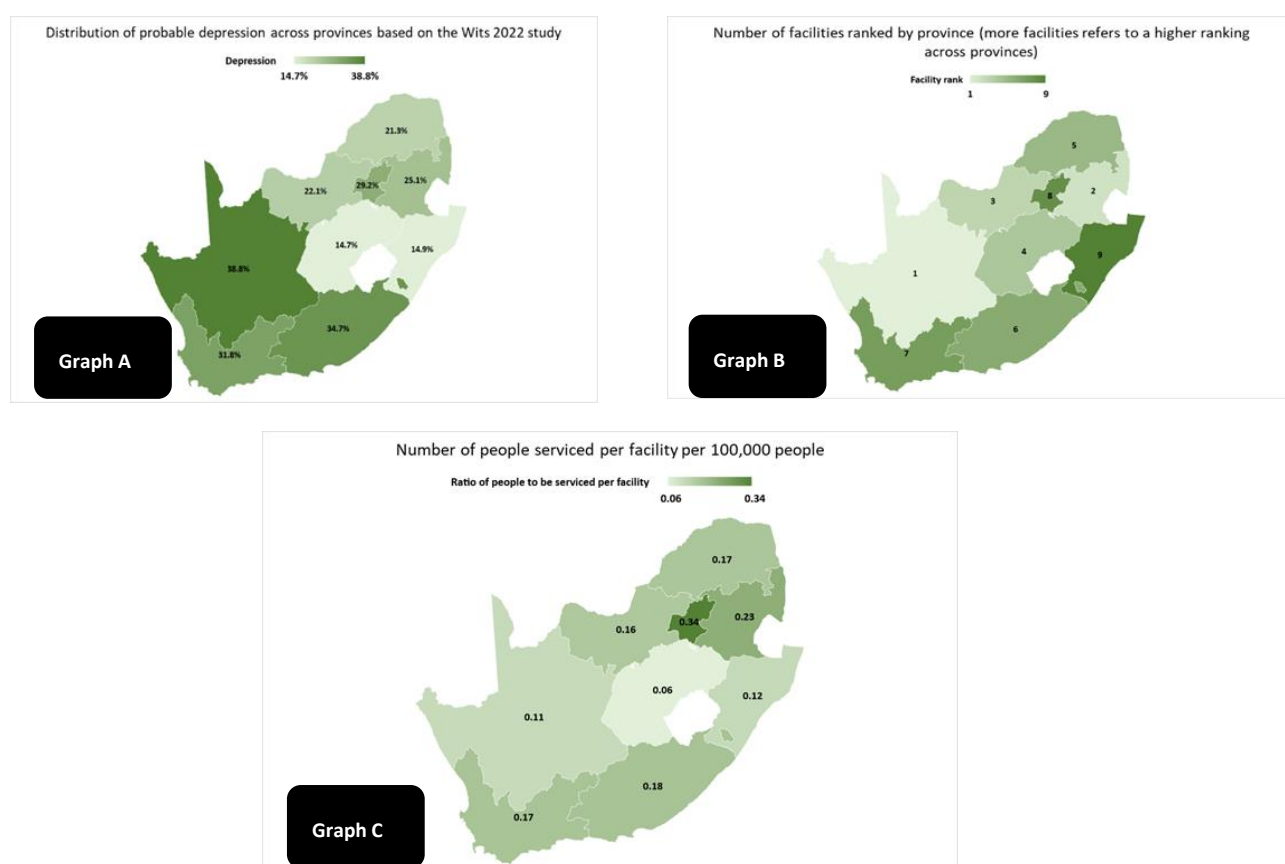
From this visual it is evident that provinces servicing the greatest number of people per facility are provinces such as Gauteng (0.34), Mpumalanga (0.23) and the Eastern Cape (0.18). In Gauteng there are 3 427 people per facility, Mpumalanga there are 2 261 people per facility, this number is 1 758 for the Eastern Cape. In contrast, provinces such as the Free State, Northern Cape and KwaZulu-Natal service less people per facility, with 594 people per facility 1 128 and 1 170 people per facility respectively.

Table 4: Number of people serviced per facility per 100,000 people by province[116]

PROVINCE	DEPRESSION	POPULATION	DEPRESSION POPULATION	TOTAL NUMBER OF FACILITIES	PEOPLE PER FACILITY RATIO	DEMAND TO SUPPLY RATIO
Eastern Cape	34.7%	6 539 000	2 269 033	1291	1 757.58	0.18
Free State	14.7%	3 000 000	441 000	742	594.34	0.06
Gauteng	29.2%	16 267 000	4 749 964	1386	3 427.10	0.34
KwaZulu-Natal	14.9%	11 822 000	1 761 478	1506	1 169.64	0.12
Limpopo	21.3%	6 168 000	1 313 784	788	1 667.24	0.17
Mpumalanga	25.1%	4 857 000	1 219 107	539	2 261.79	0.23
Northwest	22.1%	4 206 000	929 526	576	1 613.76	0.16
Northern Cape	38.8%	1 294 000	502 072	445	1 128.25	0.11
Western Cape	31.8%	7 231 000	2 299 458	1324	1 736.75	0.17

FACILITY MANAGEMENT

Facility Guidelines

The government has implemented guidelines and protocols to ensure the provision of high-quality mental health services within public healthcare facilities across South Africa. These facilities are required to adhere to specific infrastructure guidelines corresponding to their designated level of care, whether it be primary healthcare clinics, district hospitals or regional hospitals (DOH, 2011)[119].

A study conducted across district hospital facilities revealed significant disparities in meeting the requirements outlined in the Mental Health Care Act (MHCA) of 2002. A report by Docrat et. al in 2019, using 2016/2017 surveys across a sample of district hospitals in each province (except the Western Cape and Northwest who failed to provide data) found that at a national level, 84% of district hospitals sampled met MHCA requirements, but only 18% had inpatient psychiatric units, leaving most mental health patients in general wards (Docrat et. al, 2019)[17]. Although few hospitals segregated patients by age or gender, about 80% separated male and female in-patients (Docrat et. al, 2019)[17]. Across provinces, compliance varied; for example, 69% in the Eastern Cape meeting the criteria versus 100% in the Free State and 88% in Gauteng (Docrat et. al, 2019)[17]. Few provinces have inpatient psychiatric units, notably 4% in Mpumalanga and none in the Northern Cape (Docrat et. al, 2019)[17]. For specific compliance data, refer to Table 5 below, noting that the Western Cape and Northwest failed to provide this information. It will however be important to understand whether these patient splits occur during the day or at night-time – as some facilities may keep patients together during the day, splitting them in the evening.

Table 5: Sampled district hospital facilities meeting MHCA 2022 requirements.al facilities meeting MHCA 2002 requirements[17]

DIMESIONS OF DISTRICT HOSPISAL INFRASTRUTURE	EC	FS	GA	KZN	LP	MP	NC	RSA
Proportion of District Hospitals included in the sample (%)	69%	100%	80%	91%	84%	100%	100%	84%
Proportion of sampled District Hospitals designated for 72-hour Assessments by the Mental Health Care Act (2002) (%)	62%	100%	88%	81%	96%	87%	82%	84%
Proportion of sampled District Hospitals with Inpatient Psychiatric Unit (%)	14%	24%	50%	25%	19%	4%	0%	18%
Proportion of sampled District Hospitals reporting that Mental Health Inpatients are kept together with non-mental health patients in a general ward (%)	51%	0%	63%	81%	78%	96%	82%	62%
Proportion of sampled District Hospitals reporting that Adult Mental Health Inpatients are kept separate from Adolescent Mental Health Inpatients (%)	8%	0%	25%	3%	0%	30%	64%	13%

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[119] National Department of Health. (2011). Policy Guidelines on 72-hour assessment of involuntary mental health care users. Available at: https://knowledgehub.health.gov.za/elibrary/policy-guideline-72-hour-assessment-involuntary-mental-health-care-users

DIMESIONS OF DISTRICT HOSPISAL INFRASTRUTURE	EC	FS	GA	KZN	LP	MP	NC	RSA
Proportion of sampled District Hospitals reporting that Male Mental Health Inpatients are kept separate from Female Mental Health Inpatients (%)	70%	100%	75%	63%	96%	87%	36%	78%

A 2017 report conducted by the Human Rights Council (HRC) on mental health indicated that the first monitoring exercise conducted by the NDoH related to facility provision and quality of mental health services was conducted mid-2017, indicating minimal emphasis on enforcing provinces to meet requirements outlined in the MHCA (South African HRC, 2017)[120].

Investments across different provinces in South Africa

The 2022/2023 department of health annual reports and parliamentary extracts reveal extensive mental health infrastructure investments across provinces, with investments not mentioned in Northwest, KwaZulu-Natal, and Limpopo. In the Eastern Cape, over R39 million, representing approximately 6% of the mental health budget, has been allocated for 72-hour observation unit upgrades (Eastern Cape Department of Health, 2022)[121]. Gauteng has commenced renovations at Helen Joseph, Charlotte Maxeke Johannesburg Academic Hospital and Sebokeng hospitals. Additionally, a neurological development clinic has been established at an investment of R10 million (Gauteng Department of Health, 2022)[122]. Mpumalanga's plan for the development of Kwamhlnaga hospital maternity and mental ward are underway, with an estimated cost of R50 million (Mpumalanga Department of Health, 2022)[123]. In the Northern Cape, an EMS building is expected to undergo renovation and conversion into a mental health ward, with an estimated investment of R5 million (Northern Cape Department of Health, 2022)[124]. The Western Cape is investing in bed expansions and upgrades, with an estimate cost of R20 million, including the installation of a closed-circuit television system and an uninterruptable power supply upgrade to ensure service continuity during load shedding periods (Western Cape Department of Health, 2022)[125].

NGOs and NPOs

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[120] South Africa Human Rights Commission. (2017). Report of the national investigative hearing into the status of mental health care in South Africa. South Africa Human Rights Commission: South Africa. Available at:
https://www.sahrc.org.za/home/21/files/SAHRC%20Mental%20Health%20Report%20Final%2025032019.pdf
[121] EASTERN CAPE DEPARTMENT OF HEALTH BUDGET & POLICY SPEECH FOR THE 2022/2023 FINANCIAL YEAR TO THE EASTERN CAPE PROVINCIAL LEGISLATURE AT BHISHO ON 15 MARCH 2022. Available at: https://www.spotlightnsp.co.za/wp-content/uploads/2022/07/MEC-Policy-Speech-2022_23-Full-Length-Final-Version-1.pdf
[122] Gauteng Department of Health. (2021/2022). *Annual Report*. Gauteng Department of Health: Gauteng. Available at:
https://provincialgovernment.co.za/department_annual/1183/2022-gauteng-health-annual-report.pdf
[123] Mpumalanga Department of Health. (2021/2022). *Annual Report*. Mpumalanga Department of Health: Mpumalanga.) Available at:
https://provincialgovernment.co.za/department_annual/1110/2022-mpumalanga-health-annual-report.pdf
[124] Northern Cape Department of Health. (2021/2022). *Annual Report*. Northern Cape Department of Health: Northern Cape. Available here:
https://provincialgovernment.co.za/department_annual/1120/2022-northern-cape-health-annual-report.pdf
[125] Western Cape Department of Health. (2021/2022). *Annual Report*. Western Cape Department of Health: Western Cape). Available at:
https://www.westerncape.gov.za/assets/annual_report_2022-2023_.pdf

NGOs and NPOs offering mental health services typically provide day care or residential facilities, governed by national guidelines for licensing such facilities (National Department of Health, 2017)[126]. In response to the Esidimeni case, stricter guidelines and regulations were developed to improve mental health care oversight and prevent similar tragedies. These organisations must register with the Department of Social Development (DSD) and obtain licenses from the Provincial Department of Health. Licensing is required for any facility providing care to five or more Mental Health Care Users (MHCUs) (National Department of Health, 2017)[126]. These licenses ensure adherence to principles ensuring the human rights and well-being of MHCUs, with services tailored to individuals needs and cultural sensitivity (National Department of Health, 2017)[126]. District mental health teams conduct quarterly facility inspections, while the provincial government conduct annual audits with a multidisciplinary inspection team (National Department of Health, 2017)[126]. License renewals are contingent upon completion of audit recommendations and can be revoked for safety concerns or non-compliance with regulations (National Department of Health, 2017)[126]. Standards are influenced by various legislation and international conventions concerning mental health care (National Department of Health, 2017)[126].

"The norms and standards developed for day care and residential facilities are very clinical and well suited to health establishments but too rigorous for community-based organisations" - SAFMH.

According to an NGO we interviewed, stakeholders in the mental health space including NGOs and CBOs have noted that using these regulations to govern their service provisioning will result in many individuals not being able to access care they need as these institutions are struggling to meet these clinical guidelines, particularly in the cases where clinical services are provided.

The norms and standards for residential and day-care facilities follow those outlined in other legislation such as : National Building Regulations and Building Standards Act, 1977 (Act No. 103 of 1977); Public Finance Management Act, 1999 (Act No. 1 of 1999); Medicine and Related Substances Act, 1965 (Act No. 101 of 1965); Nursing Act, 2005 (Act No. 33 of 2005); Pharmacy Act, 1974 (Act No. 53 of 1974); National Core Standards for Health Establishments, 2011; The National Mental Health Policy Framework and Strategic Plan, 2013- 2020; United Nations Convention on the Rights of persons with Disabilities; The Mental Health Care Act, 2002 (Act No 17 0f 2002, and its Regulations; Regulation 158. 1996 of Health Act, 1977 (Act No. 63 of 1977); Infrastructure unit support systems (IUSS): health facility guides for mental health services, 2014; Occupational Health and Safety Act, 1993 (Act No. 85 of 1993); National Core Standards for Health Establishments, 2011; and other relevant acts (National Department of Health, 2017)[126].

The Ideal Clinic[127]

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[126] South Africa. National Department of Health. 2017. *Guidelines for the licensing of residential and day care facilities for people with mental and/or intellectual disabilities* (RP57/2017). Pretoria: Government printer. Available at: https://www.gov.za/sites/default/files/gcis_document/201705/40860gn452.pdf

[127] Department of Health on Ideal Clinic progress report. (2016). Parliamentary Monitoring Group. Available at: https://pmg.org.za/committee-meeting/22130/

The Ideal Clinic initiative, launched in 2013 by the National Department of Health in coordination with provinces, districts and PHC facility management and staff, aims to improve primary healthcare quality in South Africa (Hunter et.al,2017)[128]. Operation Phakisa tracks progress using metrics like patient safety (34%) and positive caregiving attitudes (30%). Clinics are scored as silver, gold, or platinum based on their adherence to standards. Challenges with the implementation of Operation Phakisa include infrastructure deficits, human resource constraints, supply chain inefficiencies and budgetary limitations.

The following indicators are assessed for mental health in the ideal clinic guidelines[128]:

Table 6: Categories of measures and measures used in version 9 of the Ideal Clinic Guidelines[128]

CATEGROY	MEASURE
Services Offered	Mental illness – Diagnose only
Health Support Services	Mental illness – Diagnose and treat
	Adherence counselling Mental Illness
	Mental Health (Psychologist/Psychiatrist)
Community Outreach	Support groups for NCD and Mental health
Professional Staff	Psychiatric nurse (Mental health)
Workload & Efficiency	Mental health case load (%)

These measures support the integration of mental health into PHC service delivery by understanding and measuring mental health care service delivery from diagnosis to services offered, support services through community outreach and understanding resources for service delivery.

In terms of progress with respect to ideal clinic status 74.8% of all PHC facilities met the status in 2015/2016 and this has increased over the past five years to be 83% of PHC facilities. When looking at ideal clinic status by provinces, Figure 21 shows that in 2019/2020 Gauteng was the best performing province with 91% of its facilities achieving ideal clinic status (Daven et. al,2020)[129].

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[128] Hunter, J., Asmall, S., Ravhengani, N.M., Chandran, T., Tucker, J., Mokgalagadi, Y. (2017). The Ideal Clinic in South Africa: progress and challenges in implementation. Available at: https://www.hst.org.za/publications/South%20African%20Health%20Reviews/11_The%20Ideal%20Clinic%20in%20South%20Africa_progress%20and%20challenges%20in%20implementation.pdf

[129] Daven, Jonatan & Madela, Noxolo & Wishnia, Jodi & Khoele, Aisha & Blecher, Mark. (2020). District health expenditure South Africa: trends to 19/20.

Figure 21: Percentage of PHC facilities meeting ideal clinic status by province in 2019/2020[129]
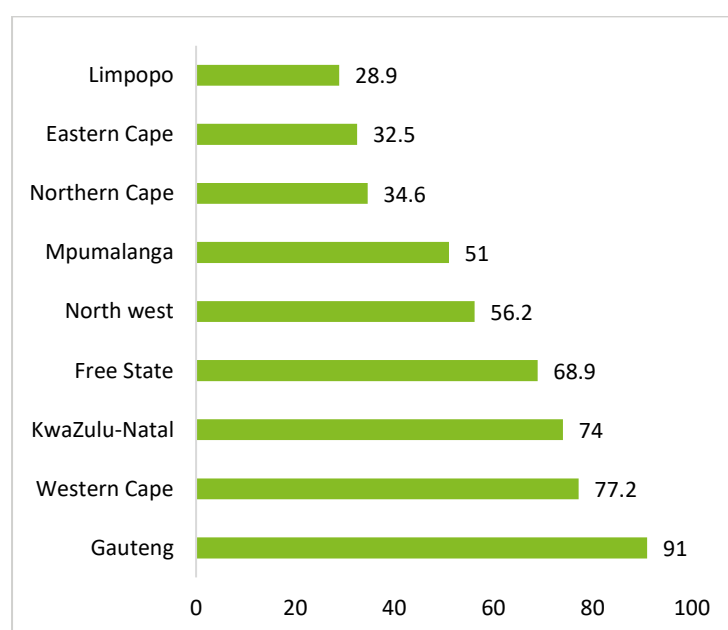
CLINICAL SERVICES

Treatment guidelines

While the private sector offers a wider range of treatment options compared to the public sector, the effectiveness of these treatments is generally similar (Basu et. al, 2012)[130]. Public sector pharmacotherapy aligns with the Essential Medicines List (EML)[131] and Standard Treatment Guidelines (STG) for primary care (2020)[132] and hospital level adult care (2019)[133] while psychotherapy adheres to the Adult Primary Guidelines 2019-2020 (APC)[134] and mental health treatment algorithms defined by the South African Psychiatry Association and the Department of Health. These guides are generally updated every three years when more relevant or new information becomes available. The last essential drug list and STGs for hospital (adults) was done in 2015 and 2019, with PHC level essential drug levels and STGs released in 2020 (National Department of Health, 2020) [135].

Regular updates to these guidelines incorporate the latest evidence-based practices and clinical insights. The development of guidelines involves collaboration among multidisciplinary teams comprising clinicians, researchers, policymakers, and patient representatives (National Department of Health, 2020)[135].

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[130] Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review. PLoS Med. 2012;9(6): e1001244. doi: 10.1371/journal.pmed.1001244. Epub 2012 Jun 19. PMID: 22723748; PMCID: PMC3378609.

[131] https://knowledgehub.health.gov.za/content/standard-treatment-guidelines-and-essential-medicines-list

[132] National Department of Health. (2020). *Standard Treatment Guidelines and Essential Medicines List Primary Care, 2020. Available at:* https://www.kznhealth.gov.za/pharmacy/PHC-STG-2020.pdf

[133] National Department of Health. (2019). *Standard Treatment Guidelines for Hospital Care 2019/2020.* Available at: sapc.za.org/Media/Default/Documents/STG hospital level adult 2019_v2.0.pdf

[134] National Department of Health. (2020). *Adult Primary Care Manual 2019/2020.* Available at: https://knowledgehub.health.gov.za/elibrary/adult-primary-care-apc-guide-20192020-updated

[135] The National Department of Health, South Africa: Essential Drugs Programme. Primary Healthcare Standard Treatment Guideline and Essential Medicine List. 7th ed. South African National Department of Health; 2020.
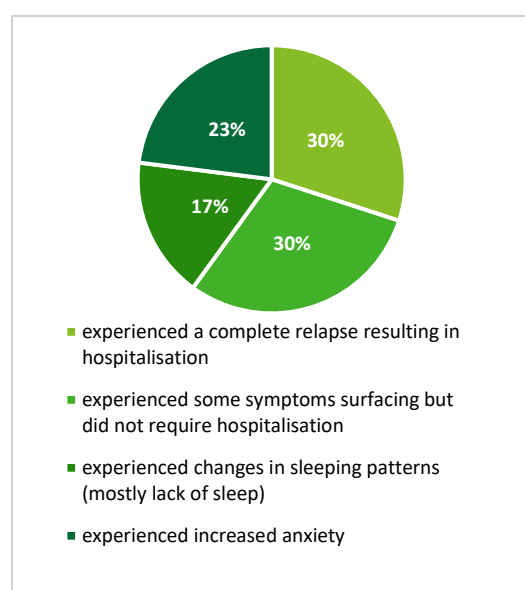
Stock outs

The National Mental Health Policy Framework and Strategic Plan 2023-2030[2] in South Africa makes the commitment that: "All psychotropic medicines, as provided on the standard treatment guidelines and essential medicines list (EML) will be available at all levels of care, including primary health care clinics". However, frequent stock-outs of mental health medication persist.

The South African Mental Health Advocacy Movement (SAFMH) conducted an engagement exercise in 2016 (SAFMH, 2016/2017)[136] on the prevalence of, and impact of medications not being available. Among 109 participating service users, 59% reported experiencing stock-outs of at least one psychiatric medication. This finding suggests a significant issue, although the actual prevalence may be higher due to underreporting. Service users may not always be aware of stock-outs as nurses frequently obtain medication from other clinics to ensure availability. This practice of borrowing can lead to reduced dosages or substitution of alternative medications, which contradicts the standard treatment guidelines specified for mental disorders.

Service users who participated in the SAFMH study indicated that they were affected by these stock outs in the following ways:

Figure 22: Impact of stock outs on life (internally and externally) in 2016/2017[136]

- experienced a complete relapse resulting in hospitalisation
- experienced some symptoms surfacing but did not require hospitalisation
- experienced changes in sleeping patterns (mostly lack of sleep)
- experienced increased anxiety

In the 2016/2017 financial year 30% of patients suffered from a relapse due to a lack of medication, which resulted in hospitalisation. Another 30% reported an increase in symptoms due to the same reason. The survey also found that 23% of patients experienced increased anxiety while 17% had their sleeping patterns disrupted. Patients reported that their personal and professional lives were affected as well through increased conflict with their families due to the unavailability of medication, having to purchase medication privately, leading to financial implications, having to visit the clinic several times to check if stock was available, and having to take time off work because their normal functioning was disrupted.

The 2017 Stop Stockouts National Survey[137] however showed that 90% of contracted facilities usually stock psychiatric medications. The results from the survey are displayed in the Table 7:

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[136] South African Federation for Mental Health. (2016/2017). Annual Report. Available at: https://www.safmh.org/wp-content/uploads/2020/09/SAFMH-Annual-Report-2016-2017.pdf
[137] Stop Stock Outs. (2017). 4TH NATIONAL SURVEY REPORT (2017) THE FRAGILE SYSTEM. Available at: https://sahivsoc.org/FileUpload/Stop%20Stockouts%20National%20Report%20Oct%202018.pdf

Table 7: Stop Stockouts survey results on psychiatric medication[137]

NAME OF MEDICINE	NUMBER OF FACILITIES THAT RESPONDED (% OF TOTAL FACILITIES IDENTIFIED)	NUMBER OF FACILITIES THAT DO NOT USUALLY STOCK THE MEDICINE.	NUMBER OF FACILITIES THAT REPORTED THE MEDICINE BEING OUT OF STOCK.	NUMBER OF FACILITIES THAT REPORTED THE MEDICINE BEING IN STOCK.	% OF FACILITIES THAT USUALLY STOCK MEDICINE THAT REPORTED HAVING THE MEDICINE IN STOCK
Amitriptyline tablets (anti-depressant)	1079 (68%)	127	49	903	95%
Citalopram tablets (anti-depressant)	1078 (68%)	396	60	622	91%
Diazepam tablets (sedative)	1077 (68%)	79	17	981	98%
Zuvlopenthixol/ Flupenthixol/ Fluphenazine (anti-psychotic)	1075 (68%)	265	80	730	90%
Haloperidol tablets (anti-psychotic)	1074 (68%)	137	41	896	96%
Risperidone tablets (anti-psychotic)	1072 (67%)	386	50	636	93%

Based on these findings in 2017, it appears that facilities had sufficient stock of essential psychiatric medications (Stop Stockouts Report, 2017)[137]. However, by 2019, stock outs for psychiatric drugs made up more than a third of the total stock outs reported to Stop Stockout. A 2019 study highlighted persistent shortages, with certain medications frequently unavailable as shown in Figure 23 (Docrat et. al, 2019)[17].

Figure 23: Mental health drugs frequently stock out across the healthcare system[17]
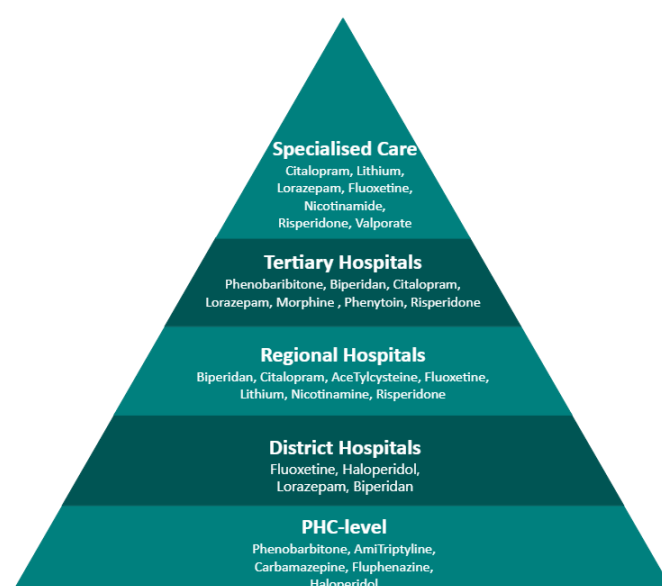
Between April and June 2020, mental health medication shortages surged with reports increasing from 3% to nearly a third by August, out of almost 280 logged shortages (Gonzalez, 2020)[138]. The Gauteng health department cited eight mental health drugs out of stock between March and August 2020. Consequently, several mental health medications are now among the approximately 150 on a nation priority list (Gonzalez, 2020)[138].

The South African Health Products Regulatory Authority (SAHPRA), responded to medication shortages by permitting the use of unregistered generics via Section 21 authorisations, aiming to alleviate the stock-outs of mental health drugs. Despite these efforts, service users express ongoing dissatisfaction, citing deteriorating mental health conditions attributed to the inability to access their prescribed medications (SAPHRA,2021)[139].

This underscores the imperative for continued collaboration and improvement among regulatory bodies, healthcare providers, and patients to effectively address these persistent challenges.

Over the last decade, the National Department of Health has rolled out a range of electronic surveillance systems to monitor medication stock outs such as RxSolution and Stock Visibility System which is a cell phone app improving use in facilities which have limited access to servers or desktop. By October 2021, it was reported that 90% of all public hospitals and clinics made use of either of these systems for stock management. However, it is important to note that these tools simply manage stock, and that in certain instances stock outs occur at a global level given problems of security of supply in the pharmaceutical industry with several drugs out of stock in the US and UK for cancer drugs and antibiotics respectively. South Africa is especially vulnerable to the global

[138] Gonzalez, L.L, (2020). 'Mental health: Are medicine shortages fueling a shadow epidemic?', Spotlight. Available at: https://www.spotlightnsp.co.za/2020/09/23/mental-health-are-medicine-shortages-fuelling-a-shadow-epidemic/
[139] South African Health Products Regulatory Authority. (2021). Access to unregistered medicines. Available at: https://www.sahpra.org.za/wp-content/uploads/2021/08/2.52_Section_21_Access_to_Unregistered_Medicines_Aug21_v3.pdf

drug supply industry as they require active ingredients from abroad to manufacture drugs. Other challenges resulting in drug stock outs include local dynamics such as failure of provinces to pay contracted suppliers on time, staff shortages in clinics (resulting in nurses having to manage stock) and delays in awarding pharmaceutical tenders (Copelyn, 2023) [140].

Prescribing of medicine

> **Use Case: Empowering Nurses to Prescribe Antidepressants and Anxiolytics in Primary Healthcare**
>
> In South Africa, professional nurses' inability to initiate psychotropic medication creates inefficiencies in treating depression and anxiety (Academy of Science, 2021)[102]. Nurses with a dispensing license can only prescribe medication up to Schedule 4, while antidepressants and anxiolytics, categorised as Schedule 5, remain beyond their scope (Academy of Science, 2021)[102]. Given the important role of nurses within mental health service delivery, efforts have been made to understand the need for reclassifying depression and anxiety medication from schedule 5 to 4, enabling nurses to prescribe treatments to mental health patients, reducing the burden on doctors and psychiatrists (Academy of Science, 2021)[102]. Stakeholders, including those involved in drafting the APC manual, support this change to streamline depression and anxiety treatment (Academy of Science, 2021)[102]. The Department of Health should have on-going discussions with the South African Nursing Council and other critical stakeholders to get their buy-in for this change, especially in rural areas where staff shortages are more severe (Academy of Science, 2021)[102]. Additional barriers to the implementation of a reduction in schedule is seen to come from the pharmacy and psychiatry councils.

CARE SERVICES, CONTINUITY, AND INTEGRATION

The referral processes

At primary healthcare level, individuals needing specialised intervention are referred to district clinical specialist mental health teams, collaborating with primary healthcare practitioners (NDoH, 2020)[98]. However, according to a stakeholder interview with NDoH[13] not all provinces have clinical specialist mental health teams and patients will then be referred to higher levels of care. Higher-level referrals entail transferring patients to regional or tertiary mental health facilities, while community-based services, offer ongoing support and rehabilitation post discharge (NDoH, 2020)[98]. The referral system should ensure efficient health system functioning, providing optimal care at appropriate levels while avoiding strain on higher levels of care (NDoH, 2020)[98].

In South Africa, the referral system faces numerous inefficiencies, including inconsistent understanding of referral timing, inadequate transport and human resources, and poorly defined links between public, private, and community-based providers. In 2011, an updated referral guide was released by the NDoH[98] to provide guidance to provincial heads of health on the requirements for listing facilities as 72-hour assessment facilities,

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[140] Copelyn, J., (2023). 'In-depth: What government is doing to reduce medicines stockouts', Spotlight. Available at: https://www.spotlightnsp.co.za/2023/10/31/in-depth-what-government-is-doing-to-reduce-medicines-stockouts/

procedures to be followed when conducting 72-hour assessments and clinical management guidelines on the assessment and treatment of mental health care users during 72-hour assessments.

A national study by Sorsdahl et. al, 2023[12] revealed that patients often exceed the 72-hour observation period in general wards due to bed shortages for high-level care referrals. It also emphasised the need to enhance post-discharge referral pathways to primary and community care to reduce relapses and readmissions. Another study by Docrat et. al (2019)[17] found that nationally patients admitted to district hospitals spend more than 8 days as an inpatient in facilities that do not meet care requirements reflecting an absence of effective referral mechanisms for the long term needs of severe MHCUs (Docrat et. al, 2019)[17].

Some provinces have implemented improvements in referral management. For example, a stakeholder in mental health in Gauteng indicated that they use a cluster referral approach, whereby patients are referred within a cluster of facilities close to where they live[141]. Additionally, the Improving Mental Health and HIV/TB Service Integration (IMHSI) project collaborates with Vula, which is a well-established medical referral app in the public sector. The Vula app (Vulamobile, n.d)[142] facilitates nationwide healthcare referrals, primarily in primary care, with ongoing implementation. In the meantime, healthcare providers should prioritise training primary nurses in mental health assessment, offering guidance on management, counselling, effective referral pathways, healthcare workers' mental health, and nursing workload management.

It is the overall responsibility of the provincial mental health directorate and district mental health specialist team to establish and coordinate effective referral pathways to ensure patients receive the correct level of care (National Mental Health Policy Framework and Strategic Plan 2023-2030)[2].

The current national referral policy is shown in the Figure 24.

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[141] Stakeholder Interview, 2023
[142] Vulamobile. (n.d). Available at: https://www.vulamobile.com/

Figure 24: Referral policy in South Africa[98]
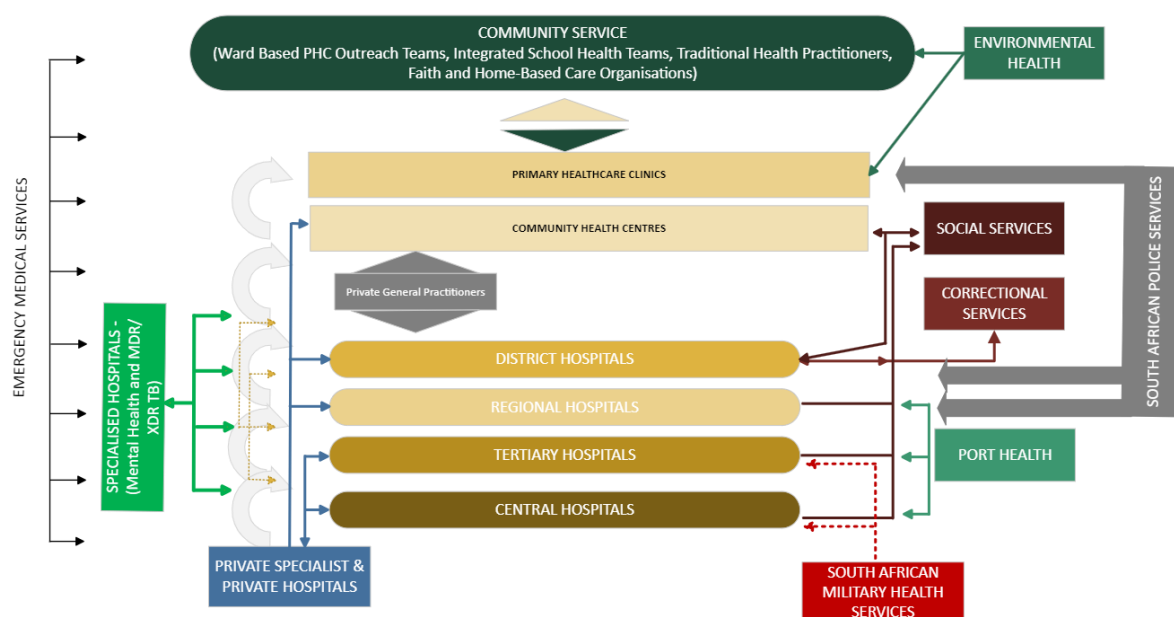
The current referral system allows for up and down referrals within and across the entire health system based on services available in the facility where the patient first presents at. EMS supports the service delivery platform within referrals by providing transport to appropriate levels of care. Any patient that requires care which cannot be provided at a health facility they present at should be referred to a facility capable of providing the level of care required. Based on the structure of the health care system in South Africa, district, or regional hospitals (in specific provincial circumstances) will be the primary point of referral from the PHC level for services. Patients may then be referred from district hospitals to higher levels of care including regional, tertiary, national and specialised psychiatric hospitals and/or central hospitals. Once the patients' healthcare needs have been met at the higher level, they can then be referred to the lowest level of care (i.e., community-based services) to receive appropriate continued support and management (National Department of Health,2020)[98].

Continued Care

In mental healthcare, after achieving stabilisation, patients should be referred to a specialised clinical team to develop or adjust their comprehensive medical, psychological, and functional recovery plan using community-based interventions (Emsley et. al,2013)[114]. Upon discharge, patients, now referred to as MHCUs, receive follow-up sessions from community health workers and a Primary Healthcare (PHC) nurse to maintain stability (Emsley et. al,2013)[114]. MHCUs are supported by community health workers with basic disability and rehabilitation competencies, supervised by professionals who collaborate on a functional recovery programme. Continuous supervision of community workers by the mental health team is essential (South Africa. Gauteng Department of Health, 2019)[104]. These out-patient services are provided by government establishments, as well as partnerships with NGOs and CBOs.

Community mental health services, funded through Primary Healthcare (PHC) budgets, provide outpatient care from PHC clinics and residential and day care facilities (Docrat et. al, 2019)[17]. Nursing staff are responsible for medication management, monthly mental health assessments, referrals coordination, psychoeducation and community mental health awareness (Robertson & Szabo, 2017)[143].

Telemedicine plays a crucial role, particularly in rural areas, to ensure ongoing care. Engagement in self-help groups, mentorship, and social activities is essential for preventing relapse among Mental Health Care Users (MHCUs).

INTEGRATING MENTAL HEALTH INTO PRIMARY HEALTH CARE

Health service integration involves delivering care for multiple conditions concurrently to alleviate strain on healthcare systems. For example, providing antiretroviral therapy (ARVs) and mental health support simultaneously to HIV patients. Task-sharing is necessary within this integrated framework due to a shortage of mental health specialists in primary healthcare.

Multiple policies and guidelines have consistently advocated for the integration of health services, including the Mental Health Care Framework and Policy 2023-2030. The implementation of integrated health service has been insufficient on the ground (South Africa Mental Health Care Framework and Policy 2023-2030)[2]. Although many provinces express intentions to move towards integration, significant barriers hinder progress in others. Gauteng's Head of Occupational Therapy, working frequently with MHCUs has expressed that integration is necessary so that PHC can manage basic anxiety and depression and referrals to higher levels can be done at the first entry point.[141] The division of work will also allow patients to receive treatment faster and not be stuck at busy ques in clinics where mental health is still stigmatised.

In primary health clinics, the PHC Mental Disorders treatment rate can potentially serve as a tool for tracking progress in integrated mental health services. By measuring the number of new patients seeking mental health illness treatment against the total patient visits, it offers valuable insights into the extent to which mental health services are integrated into the primary healthcare setting. The Barometer 2023 (Ndlovu & Paradarath, 2024)[144] reports has been used to analyse the indicator's performance over the past 3 years at the district level. The ranking system provided in the Barometer report, enables the assessment of district-level performance. The ranking system defines the position of each district relative to others based on their performance on the mental disorders treatment rate indicator. District are ranked from 1 to 52, with 1 being the best and 52 the worst. Districts were grouped into three "buckets' based on their rankings: top (1-24), middle (25-28) and low (29-52). No mental disorders treatment rates as reported for the Western Cape and was therefore excluded from the analyses and the top end of the ranking was adjusted from 52 to 46.

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[143] Robertson LJ, Szabo CP. Community mental health services in Southern Gauteng: An audit using Gauteng District Health Information Systems data. South African Journal of Psychology. 2017;23(0), a1055. https:// doi.org/10.4102/ sajpsychiatry. v23i0.1055

[144] Ndlovu N, Padarath A, editors. District Health Barometer 2022/23. Durban: Health Systems Trust; February 2024.

The findings in Figure 25 indicate a significant improvement in mental health treatment rates within primary healthcare facilities, particularly in KwaZulu Natal. The province witnesses a notable increase from 3 to 9 districts ranking highly for mental illness treatment rates. This improvement means that 82% of KwaZulu-Natal's districts are now among the top performers in mental disorders treatment rates. Additionally, over the last three years, 8 out of the 11 districts in KwaZulu-Natal have experienced a marginal increase in treatment rates, indicating consistent progress in integrating mental health services into PHC clinics.

Similarly, Gauteng has maintained its position in the top ranking for mental disorders treatment rates over the past three years, reflecting ongoing investment and efforts to integrate mental health into PHC facilities.

Conversely, provinces such as Free State, Limpopo, Northern Cape, and Northwest have faced challenges, with some of their districts experiencing declines in treatment rates.

Among the 46 districts, only 6 reported mental disorders treatment rates higher than ~0.1. This subset of districts represents a notable proportion with treatment rates exceeding the threshold, indicating potentially higher levels of mental health service utilisation or effectiveness in these areas. Two of these districts were ranked among the top 20 in terms of population size, suggesting that densely populated areas may exhibit higher demand for mental health services. However, the specific characteristics and factors contributing to the elevated treatment rates in these districts warrant further examination. The findings underscore the need for sustained efforts to strengthen health integration within primary healthcare systems across South Africa.

Another valuable data source providing insights into mental health care provision at the primary healthcare (PHC) level is the District Health Information System (DHIS). The DHIS collects data on annual mental health caseloads across all facilities in South Africa, indicating changes in outpatient mental health clients over time[27].

Mental health caseload is defined as mental health care visits as a proportion of total primary healthcare (PHC) plus outpatient department (OPD) headcount. This indicator is used to monitors mental health workload at ambulatory services. Figure 26 illustrates fluctuations in mental health caseload across South Africa provinces from 2017 to 2023. Gauteng Province consistently reports high than average values, suggesting a relatively higher mental health caseload compared to other provinces. Conversely, Mpumalanga Province consistently reports lower than average values. One trend observed is a general increase in mental health caseload averages from 2017 to 2020 across most provinces, followed by a slight decline or stabilisation in subsequent years. There are exceptions, such as KwaZulu-Natal and Northern Cape, which continue to show increases in mental health caseload averages up to 2023. Insights from these trends could suggest varying levels of mental health service utilization and need across provinces. Factors such as population demographics, healthcare infrastructure, socio-economic conditions and mental health awareness campaigns may contribute to these differences. While the overall trend shows fluctuations in mental health caseload averages across provinces over the years, further analysis is needed to understand the underlying factors driving these variations.

Figure 26: Change in total mental health caseload as a proportion of total PHC and OPD headcount over time[27]
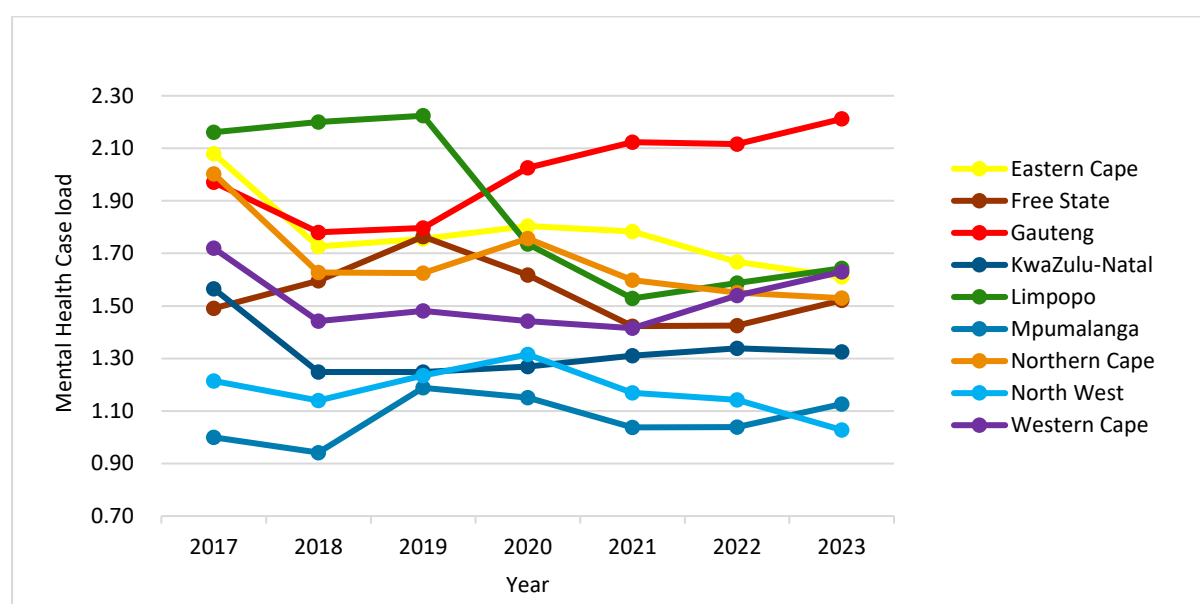
BARRIERS TO INTEGRATING MENTAL HEALTH INTO PRIMARY HEALTH CARE

A study conducted in KwaZulu-Natal focused on the experiences of professional nurses in integrating mental health care into primary healthcare specifically within the iLembe district (Madlala, Miya and Zuma, 2020)[145]. The 17 participants included professional nurses working with mental healthcare users at primary healthcare centres and level 1 district hospitals. Among the participants, various barriers to integration were identified.

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[145] Madlala, S.T., Miya, R.M. & Zuma, M., 2020, 'Experiences of mental healthcare providers regarding integration of mental healthcare into primary healthcare at the iLembe health district in KwaZulu-Natal province', Health SA Gesondheid 25(0), a1143. https://doi.org/10.4102/ hsag. v25i0.1143

These included a **shortage of both sufficient and trained staff**, particularly a decline in nurses with specialised training in advanced psychiatry. As a result, mental health workers often find themselves performing tasks beyond their scope, which impacts their career progression and safety. Participants noted that **the current referral system**, characterised by unclear admission criteria, contributing to overcrowding at clinics, attracted many mental healthcare users. This influx strained resources and led to concerns about providing effective care. Participants also emphasised the necessity for accurate and efficient referrals processes, stressing improved coordination and communication among healthcare providers to ensure seamless integration of mental health care into primary healthcare settings and preventing patient relapses.

Insufficient financial and human resources pose barriers to integrating mental health into primary healthcare. Adequate funding is necessary for essential materials and personnel, including properly planned infrastructure. **Professional nurses require support from management**, including access to psychotropic medications for mental health patients, to enhance treatment adherence and prevent relapses due to medication unavailability at PHC facilities. These constraints often lead to suboptimal service delivery, potentially resulting in litigation and heightened job stress, further compromising staff performance (Madlala, Miya and Zuma, 2020)[145].

> **BARRIERS TO INTEGRATION**
>
> - A shortage of both sufficient and trained staff in particular nurses specialised in advanced psychiatry. As a result, staff find themselves performing tasks not part of their job description
>
> - The current referral system has unclear admission criteria resulting in overcrowding
>
> - Insufficient financial and human resources pose barriers to the integration of mental health into PHC
>
> - Professional nurses require support from management including access to psychotropic medications due to medication unavailability at PHC facilities

The HIV/AIDS, TB and STI National Strategic Plan (NSP), allows for the integration of mental health services into primary healthcare, but implementation is hindered by financial and human resource constraints. Clear financial planning is necessary to support policy and programme execution, ensuring comprehensive integration. Despite existing policies and programmes, resource limitations lead to non-adherence and incomplete integration.

The Perinatal Mental Health Project (PMHP)[146] exemplifies successful integration with public healthcare, operating collaboratively within maternal outreach units in Cape Town to provide comprehensive maternal and mental health care. Through screening and counselling services, along with staff training initiatives, the PMHP has increased screening rates, improved service uptake and reduced loss to follow-up, demonstrating effective integration of mental health services into maternal care.

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[146] Perinatal Mental Health Project. (n.d.) Available at: https://pmhp.za.org/

PRIME Case Study[147,148,149,150]:

The Programme for Improving Mental Health Care (PRIME) study in South Africa aimed to integrate mental health services into existing healthcare platforms by customising a mental health care plan (MHCP) at the district-level, targeting collaborative care packages for depression, alcohol use disorders, and schizophrenia. The study was initiated in 2010 in Kenneth Kaunda (Northwest province) in South Africa across 4 hospitals, 1 mental hospital, 9 community health centres, 28 primary healthcare clinics and 14 mobile clinics of which 14% of the population was rural. The study was also conducted in a district in Ethiopia, India, Nepal and Uganda. Through the PRIME study, primary care nurses achieved significant improvement in the detection and management of depression and alcohol use disorders, with 55.2%, of individuals with depression showing clinically significant improvement under the guidance of trained primary care nurses. Success strategies of PRIME included tailored training materials for non-specialists, careful development of roles and scope of work, and health system strengthening initiatives such as continuous quality improvements and establishment of referral pathways (Mokgaola et. al, 2022, Schiender et. al, 2016, and Truter, 2023)[147,148,149,150]

Integrating mental healthcare into primary healthcare demands a comprehensive strategy. Case studies underscore the necessity for continual investment in developing a multisectoral mental health national strategic plan with measurable objectives and standardised referral pathways. Enhanced collaborations with community organisations and governmental agencies are imperative for integrating psycho-social support interventions with economic empowerment activities. These collaborative activities address the diverse needs of individuals accessing mental healthcare services in primary healthcare settings.

Mental health programmes

For this report we have categorised mental health programmes in South African into six types (1) Suicide prevention programmes, (2) Mental health awareness and anti-stigma programmes, (3) Early-childhood development programmes, (4) School based mental health prevention and promotion, (5) Parental, maternal mental health promotion and prevention, (6) Work related mental health prevention and promotion. Many of these programmes are provided comprehensively by the same providers.

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[147] Madlala, S.T., Miya, R.M. & Zuma, M., 2020, 'Experiences of mental healthcare providers regarding integration of mental healthcare into primary healthcare at the iLembe health district in KwaZulu-Natal province', Health SA Gesondheid 25(0), a1143. https://doi.org/10.4102/ hsag.v25i0.1143
[148] Mokgaola, I.O., Gause, G., Sehularo, L.A., Molato, B., Meno, O.F., and Sepeng, N.V., (2022). 'The Status of Integrating Children and Adolescents' Mental Health Care Servoces into Primary Health Care in South Africa: Scoping Review.', The Open Public Health Journal, 15(1). DOI: 10.2174/18749445-v15-e221128-2022-75
[149] Schiender, M., Docrat, S., Onah, M., Tomilnson, M., Baron, E., Honikman, S., Skeen, S., van der Westhuizen, C., Breyer, E., Kagee, A., Sorsdahl, S., and Lund, C. (2016). South African Human Rights Annual Report. Chapter 13: Integrating mental health into South Africa' s health system : current status and way forward. Available at: https://pmhp.za.org/wp-content/uploads/SAHR2016_chapter13_Integrating_mental_health.pdf
[150] Truter ZM. Collaborative care for mental health in South Africa: a qualitative systematic review. South African Journal of Psychology. 2023;53(1):18-31. doi:10.1177/00812463221093525150 This tool makes reference to the WHO Mental Health Gap Action Programme (mhGAP) guidelines which provides a set of evidence-based guidelines for non-specialists on how to manage mental health conditions within a task sharing approach at PHC.

Suicide prevention programmes aim to reduce suicide risk by improving access to care and strengthening social support and coping skills. Mental health awareness initiatives seek to combat stigma by promoting understanding and open discussions.

Early child development (ECD) programmes provide holistic support to mothers and children during their critical formative years, addressing developmental needs such as love, safety, and nutrition, alongside emotional and social development. Examples include the **SmartStart** programme[151] and **the Ikamva Labantu Development Programme**[152], which offer resources and training to caregivers and educators. Initiatives like the Thula Sana Home Visiting Programme[153] receive support from organisations such as the World Health Organization (WHO) and other global health entities, which advocate for maternal and child mental health services. The **Side-by-Side Campaign**[154], launched in partnership between the National Department of Health (NDoH), academic institutions and various global and local organisations, emphasises collaboration among stakeholders to promote nurturing care for children under five. These efforts collectively engage a diverse range of sponsors and advocates to ensure comprehensive early childhood mental health support.

School based mental health programmes, managed by educational authorities in collaboration with health and social development departments, receive advocacy and support from various stakeholders. UNICEF and the Child Gauge (South African Child Gauge, 2019)[155] team advocate for child involvement and increased investment in mental health services. Programmes such as the Integrated School Health Programme, resilience-building initiatives, mindfulness training, peer support, counselling services, and social-emotional learning are managed by educational authorities. These programmes benefit from collaboration with local mental health organisations, which contribute resources and support including training for teachers and counselors, workshops, support groups, and direct service to students. These partnerships and advocacy efforts are integral to ensuring the effectiveness and sustainability of school-based mental health initiatives.

> **Case Study: Addressing Mental Health issues in the Ndlovu Care Group**[156]
>
> The Ndlovu Care Group in Groblersdal takes a comprehensive approach to address mental health stigma within their community through education and community engagement. They prioritise awareness and destigmatisation by offering various programmes and services, including Early Childhood Development (ECD) support, skill training, nutritional units, disability programme and safe spaces for children. In 2021 there were 161 learners enrolled, a 41% decrease from the year before. Collaborating with spiritual leaders, they ensure widespread dissemination of information and resources to effectively tackle mental health issues. Their commitment to providing free medical services ensures accessibility to mental health support for all community

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[151]Smart Start. (n.d.). Available at: https://smartstart.org.za/
[152] Ikamva Labantu , (n.d.). Available at: https://ikamva.org.za/programmes/
[153] WHO, (2019). 'Thula Sana - A home-visiting programme for mothers with young infants - Faciliator manual' . Available at:
https://www.who.int/publications/m/item/Thula-Sana-A-home-visiting-programme-for-mothers-with-young-infants-Faciliator-manual
[154] Side-by-Side, (n.d.). Available at: https://sidebyside.co.za/
[155] South African Child Gauge, (2019). ;'*Child and adolescent health: Leave no one behind'*. Available at:
https://www.unicef.org/southafrica/media/4351/file/ZAF-Policy-brief-child-adolescent-health-child-gauge-2019.pdf
[156] Foundation for Professional Develop. (2022). Mental Health and Psycho-Social Support Services (MHPSS) for Children, Adolescents and Young People in South Africa: An Integrated, Intersectoral Approach
UNICEF Roundtable.

members, promoting holistic well-being and inclusion. In 2021, 80% of the learners achieved an average pass and 128 children graduated from the ECD centres to start primary school in 2022.

Parental, maternal mental health promotion and prevention programmes are focused on providing mental health support to mothers and expecting mothers, which will extend to their children. MomConnect[157] facilitates young women's clubs during prenatal and postnatal periods, and there are mental health programmes like the Postnatal Depression Support Association of South Africa (PNDS)[158], the Perinatal Project in Cape Town[144], and the Mom and Babies Programme by Stellenbosch University[159] focusing on maternal mental health support during and after pregnancy. The Nurturing Care Framework[160] in South Africa prioritises maternal and child mental health within early childhood development.

Mothers-2-Mother Case Study[161]

The National Department of Health and UNICEF are supporting a peer mentor programme by Monthers2Mothers (M2M) and Health Systems Trust (HST) across various districts in KwaZulu-Natal. M2M employs mentor mothers while HST recruits peer educators to provide group education, one-on-one counselling, and peer-based mentoring to clients, including support for young mothers and screening for various health issues. M2M operates at twenty facilities across eThekwini and uMgungundlovu, while HST operates at nine facilities in Zululand and eleven facilities in uThukela.

Work-related mental health support encompasses various programmes, such as employee assistance programmes offering confidential counselling and mental health first aid training. Companies often implement occupational health and safety initiatives to foster safe and healthy environments.

Programme Providers

This section provides an overview of some of the many mental health programmes available in South Africa, however this is not an exhaustive list.

NPOwer (South Africa)[162]: Established in 2020 during the Covid-19 pandemic, NPOwer offers free mental health care and support to non-profit organisations (NPOs). Its services, including a dedicated helpline, crisis interventions, follow-up calls, monthly support group meetings, and webinars, are available in all 11 official languages of South Africa. The helpline operates 24/7, aiding NPO leaders, staff and volunteers experiencing strain and burnout.

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[157] MomConnect, (n.d). Available at: https://www.health.gov.za/momconnect/
[158] Post-Natal Depression Support Association mof South Africa, (n.d.). Available at: https://disabilityconnect.co.za/post-natal-depression-support-association-of-south-africa-pndsa/
[159] Stellenbosch University, (2021). ;Researcher designs wellness programme for single moms'. Available at: https://www.sun.ac.za/english/Lists/news/DispForm.aspx?ID=7977
[160] Side-by-Side Campaign, (n.d.). 'Nuturing care framework'. Available at: https://nurturing-care.org/resources/nurturing-care-case-study-south-africa.pdf
[161] Mothers-2-Mothers. (n.d.). 'What we do – Where we work'. Available at: https://m2m.org/what-we-do/where-we-work/south-africa-2/
[162] NPOwer Mental Health Support - Helpline 0800 515 515 - Home (npowersa.org)

South African Depression and Anxiety Group[163]: With operations since 1994, SADAG is a leading advocate for mental health issues in South Africa. It operates a 24/7 Suicide Crisis Helpline, which receives over 2,500 calls daily nationwide. SADAG also hosts support groups across the country, conducts educational campaigns, and offers a referral service to mental health professionals. SADAG provides free multilingual brochures on various mental health issues.

Lifeline South Africa[164]: Provides crisis intervention and emotion support services through its 24/7 hotline, staffed by trained volunteers. Lifeline operates various helplines for specific issues such as HIV/AIDS and gender violence. Physical centres have been established in regions across South Africa, offering additional support services. Lifeline's services are accessible to individuals in distress. Lifeline funds the provisioning of these services through corporate and individual donations as well as forming partnerships with Department of Health, Department of social development, Gauteng provincial department of social development, Redcross, Nacosa, other similar organisations.

South African Federation for Mental Health[165]: Founded in 1920, is the largest national mental health federation in South Africa. It supports mental health care users through advocacy, awareness campaigns, and empowerment programmes. SAFMH collaborates with government departments and other stakeholders to streamline mental health services. SAFMH's network compromises a national office, 17 constituent bodies, and about 100 member organisations nationwide.

South Africa Health Advocacy Movement (SAMHAM)[166]: Empowers individuals with psychosocial and intellectual disabilities across South Africa. It conducts empowerment sessions in all nine provinces and advocates for policy changes to protect the rights of individuals with disabilities. SAFMH partners with the Department of Health and provides services to various stakeholder, including individuals, families and policy makers. Some of the programmes hosted by SAFMH includes **The Speak Your Mind (SYM)[167]** Campaign, which is a nationally driven and globally united campaign, advocating for ending the silence around mental health.

TEARS Foundation[168]: Is a leading anti-sexual violence organisation which provides support and assistance to survivors of rape and abuse, including those who may be at risk for self-harm or suicide. The helpline is staffed by trained counsellors who provide emotional support, crisis intervention and referrals to appropriate services. TEARS also provides counselling and legal assistance.

[163] South African Depression and Anxiety Group, (n.d.). Available at: South African Depression and Anxiety Group (sadag.org)
[164] LifeLine South Africa, (n.d.). Available at: Home - LifeLine South Africa (lifelinesa.co.za)
[165] South African Federation for Mental Health, (n.d.). Available at: South African Federation For Mental Health - Mental Wellness Experts (safmh.org)
[166] South African Mental Health Advocacy Movement, (n.d.). Available at: South African Mental Health Advocacy Movement (SAMHAM) | MHIN (mhinnovation.net)
[167] Speak Your Mind Campaign, (n.d.). Available at: https://freeyourmindinitiative.com/speak-your-mind/
[168] Tears Foundation, (n.d.). Available at: TEARS Foundation is a Leading anti-sexual violence organization

The Department of Social Development (DSD) indicated that through its subsidiaries it was supporting 218-day care centres and 146 residential facilities. The number of centres varied across provinces, with 67 in Gauteng, 8 in the Northern Cape. Additionally, DSD supports SAFMH stigma related programmes, as well as supporting social worker posts in CBO settings. 3 852 social worker posts are subsidised in this manner, while 39 are employed directly by the Department. The DSD employs 8 664 social workers in the provinces and 3 852 posts are subsidised (SAHRC,2017)[120].

HUMAN RESOURCING

Staff provisioning

Within the healthcare system, various healthcare workers provide services across primary to tertiary level service provisioning, each contributing to mental health service delivery according to their expertise (Academy of Science, 2021)[102]:

Table 8: Staff members and their roles[102]

STAFF MEMBER	RESPONSIBILITY IN MENTAL HEALTH SERVICE DELIVERY
Community health workers, community rehabilitation workers and community care givers	Provide screening, supporting people with MNS disorders in treatment and community-based rehabilitation. As part of the WBOTs under the re-engineering of PHC, their responsibilities include promoting overall health & wellbeing, providing information & health education, conducting household screening and profiling of health needs, providing appropriate direct basic services such as counselling and psychosocial support, facilitating referrals for rehabilitation and social support, providing adherence support for people on medication (delivery of medication) and run community awareness campaigns.
Nurses	Play a primary role in screening, assessment, and case management of people with MNS disorders. Psychiatric nurses provide specialised support and training to PHC nurses and may also be involved in community-based rehabilitation programmes. They are essential in both outpatient and inpatient settings for managing individuals with mental disorders. Nurses can identify and assess individuals for MNS disorders using the Adult Primary Care (APC) clinical tool.[169]
Medical practitioners	General practitioners who complete a diploma in mental health can assume a more specialised role in the management of mental, neurological and substance use disorders. Clinical associates, despite their limited mental health training, can undertake clinical tasks for these disorders under the supervision of medical practitioners.
EMS staff	EMS providers provide pre-hospital care for individuals experiencing mental health crisis, especially those at risk of harming themselves or others.
Occupational Therapists	This group includes occupational therapists, community rehabilitation workers and occupational therapy assistants. These healthcare workers are trained in rehabilitation including physical, psychosocial, educational, vocational, and community-based programmes for individuals and groups.

[169] This tool refers to the WHO Mental Health Gap Action Programme (mhGAP) guidelines which provides a set of evidence-based guidelines for non-specialists on how to manage mental health conditions within a task sharing approach at PHC.

STAFF MEMBER	RESPONSIBILITY IN MENTAL HEALTH SERVICE DELIVERY
Psychologists	This group includes psychometrists, registered counsellors, clinical, counselling, educational, industrial and research psychologists. These staff members effectively deliver manualised psychosocial interventions and provide evidence based psychological interventions.
Social Workers	Social workers, Social Auxiliary workers, Child and youth care workers (working under the supervision of social workers supporting children in need or care). Provides interventions to secure social and family well-being of individuals with MNS disorders through individual and group interventions.
Psychiatrist	Provide specialised psychiatric assessments and interventions in community and hospital settings. Play an important role in training, mentoring, supervision, and clinical consultations services for patients with complex/severe MNS disorders. There are sub-specialists who provide services in their areas of speciality including child and adolescent psychiatry and mental health, forensic psychiatry etc. Psychiatrists at general hospitals may provide out-patient follow up visits for the provision of psychotropic medication, psychological treatments and psychosocial group therapies for mental health and substance-use conditions.
Neurologists	Management of all neurological disorders and train, supervise and mentor other health service providers.

Each of these staff members have a distinct scope of work. Despite their role, not all professionals receive adequate training in mental health care, leading to disparities in service quality and access.

Training gaps

A report by the Academy of Science[102], investigated the extent of education of each of these staff groupings and what additional support is needed in working with MHCUs. Some notable training needs identified include:

Community rehab workers and care givers, require more training on MNS disorders and ongoing support for screening. A 2011 survey highlighted deficiencies in CHW training and certification. The PHC re-engineering project was introduced in 2010 with the aim of shifting the focus of primary health care to a health-promoting community-based model. PHC re-engineering intends to integrate CHWs into municipal ward-based teams as permanent employees of the provincial health department to ensure career advancement and support.

The public-private sector debate concerns the government's limitation on private institutions producing doctors and **nurses**. Despite a significant nurse shortage of 45,000, Netcare's nursing college only trains 15 nurses annually. Concerns also arise regarding nurse education quality specific to mental health services, seen in the discontinuation of the Advanced Diploma in Psychiatric Nursing and insufficient coverage of Mental and Neurological Disorders in updated curricula aligned with the National Qualification Framework (NQF).

Medical practitioners, although proficient in mental health, medical practitioners have training gaps in identifying and managing individuals with substance use disorders and in assessing disability. There is a need for enhanced competence in working with multidisciplinary teams to facilitate recovery and rehabilitation for individuals with Mental and Neurological Disorders.

Occupational therapists (OTs) in South Africa needs enhancement, particularly in addressing co-occurring mental, developmental, and neurological disorders. **Social workers** also require improved training, especially in substance use disorders, as highlighted in the report, where current education standards do not meet evidence-based international criteria.

Psychologists encounter a lack of standardisation in training and curricula across institutions. Substance abuse training needs more attention, with a shift towards community-based recovery-oriented approaches. **Registered counsellors**, excluded from the national PERSAL system, struggle to access benefits, leading to halted programmes. **Psychiatry** training should prioritise community care over hospital-based care, and neurologists, primarily in urban areas, should train general health practitioners for community settings to address shortages.

Staff component per population

In South Africa, mental health care facilities suffer from severe understaffing and lack of appropriate personnel to deliver services. For psychotherapy the appropriate staff complement would include psychologists, psychiatrists, and licensed social workers. However, the staff to population ratio in South Africa is severely constrained.

Figure 27 ranks each province based on number of staff per 100 000 South Africans. Provinces were ranked by each staff category. The highest ratio of staff per 100 000 people was ranked number one (green on the colour scale) for that staff type and lowest staff ratio per 100 000 people was ranked last (red on the colour scale). If a province didn't have a staff type, they were not ranked and subsequently "greyed" out of the ranking. After ranking the provinces by each category, the provinces were ranked on their total performance across categories to get a total rank. Western Cape resulted in ranking number 1 overall and the Mpumalanga ranked last overall as can be seen in the first row of the table.

Figure 5:Province Rating by Staff per 100,000 (Docrat et. al, 2019)[17]

	WC	NC	GT	KZN	EC	LP	NW	FS	MP
Total Rank									
Psychiatrists Rank									
Sessional psychiatrists Rank									
Psychiatry registrars Rank									
Child psychiatrists Rank									
Child psychiatry registrars Rank									
Psychologists Rank									
Psychologist (community service) Rank									
Psychologist intern Rank									
Medical officers Rank									
Medical officer (community service) Rank									
Medical officer (intern) Rank									
Occupational therapist (grades 1–3) Rank									
Occupational therapist (community service) Rank									
Speech therapists and audiologists (grades 1–3) Rank									

Social worker Rank									
Professional nurse Rank									
Professional nurse specialty Rank									
Professional nurse (community service) Rank									

At a national level in South Africa, there is a significant disparity in mental health care service providers per 100,000 population across different categories. Appendix C shows the ratio of provincial staff per 100,000 people. For instance, with only 0.31 psychiatrists available for every 100,000 people, compared to 27.23 nurses, empowering nurses to take on expanded roles aims to improve access to mental health services. The implementation of task sharing seeks to optimise resources, enhance accessibility, and provide more comprehensive care for patients with mental health needs. The availability of human resources for child and adolescent mental health is even scarcer, with only 0.02 child psychiatrist per 100,000 children. Similarly, there are only 0.02 sessional psychiatrists and 0.01 psychiatry registrars per 100,000 people nationwide. Occupational therapists are also limited, with a national average of 1.53 per 100,000 population, and fewer staff reported for community service therapists. The national average for speech therapists and audiologist stands at 1.07 per 100,000 people (Docrat et. al, 2019)[17]. The information provided by Docrat et. al (2019) does not specify mental health nurses, but instead reports on professional nurses.

Additional sources of information to consider on human resources for mental health includes the Mental Health Atlas for South Africa (2020)[14]. The table below provides an overview of the number of mental health workers in South Africa as per the Mental Health Atlas 2020 as well as other countries such as Australia and Canada with good mental health systems and Brazil as a middle-income country to allow for a comparison of human resources. Table 9 also shows the disparities between human resources reported in the WHO Atlas and a recent 2019 national study by Docrat et. al (2019). Medical human resources considered as other specialised mental health workers for Docrat et. al (2019) includes occupational therapists and speech therapists.

Australia and Canada report much higher values for human resources (per 100,000 people) for psychiatrists and psychologists but fewer for mental health nurses when compared to South Africa. Canada shows more social workers per 100,000 people than compared to South Africa and information is missing for Australia. Canada reported a much lower average than South Africa for other specialised mental health workers which could indicate that South Africa makes use of different levels of health workers to provide care across the mental health service delivery system. One example of this could be the use of community lay workers, which may not necessarily be used in other international countries.

Brazil as a middle-income country, reported higher averages than South Africa for psychiatrists and other specialised mental health workers, but reported lower averages than South Africa for mental health nurses,

psychologists and social workers. Child and adolescent psychiatrists' information was missing for Australia, Canada and Brazil and so comparisons to South Africa could not be done.

Table 9: Number of staff per 100,000 people across four countries in 2015/2016/2017 from the WHO Global Health Observatory with South Africa data coming from the 2019[12,17, 170, 171, 172]

Staff member	South Africa (WHO Atlas 2020) / Docrat et. al Study (2016/2017 data)	Brazil	Canada	Australia
Psychiatrist	1.59 / 0.34	3.17	14.68	13.5
Mental health nurses	242.62 / 114.7	0.13	70.28	87.92
Psychologists	15.36 /1.39	12.37	48.74	103.04
Social workers	86.23 / 1.83	6.61	145.4	-
Other specialised mental health workers	14.73 / 3.21	139.23	4.12	-
Child and adolescent psychiatrists	0.11 /0.03	-	-	-

The national 2019 study by Docrat et. al, also shows regional variations, with the Western Cape having the highest number of psychiatrists per 100,000 population (0.89), whereas Eastern Cape, KwaZulu-Natal, and the Northwest report the lowest numbers (0.1, 0.12, 0.12 respectively). Similar patterns are observed for psychologists, with provinces like Western Cape (1.22), Gauteng (1.38), Limpopo (1.22), and the Northern Cape (3.28) having the highest number per 100,000 people. However, community service psychologist and intern psychologists are limited across all provinces, with Gauteng reporting the most staff (0.26 community psychologist and 0.16 intern psychologist per 100,000 people) and Northwest having the fewest. More recent statistics report (Teichman, 2022)[173] that in 2022 vacancy rates were between 80% and 83% in Mpumalanga, Limpopo and the Eastern Cape. The shortage of psychiatrists in the public sector is even more severe, with a psychiatrist-patient ratio of 1 to 3,338,295 for the Eastern Cape and 1 to 1,581,194 in Mpumalanga.

The shortage of mental health professional is further exacerbated in rural communities, where only 62 (38.7%) of 160 public rural primary healthcare facilities employ mental health nurses, serving a population of over 17 million with only 116 mental health nurses (0.68 mental health nurses per 100,000 population) (Moodley, Wolvaardt and Grobler, 2022)[174].

[170] WHO, (2020). ;'World Mental Health Atlas : Brazil 2020' . Available at: https://www.who.int/publications/m/item/mental-health-atlas-bra-2020-country-profile
[171] WHO, (2020). ;'World Mental Health Atlas : Canada 2020' . Available at: https://www.who.int/publications/m/item/mental-health-atlas-can-2020-country-profile
[172] WHO, (2020). ;'World Mental Health Atlas : Australia 2020' . Available at : https://www.who.int/publications/m/item/mental-health-atlas-aus-2020-country-profil
[173] Teichman, C. (2022). 'Mental health for all is not a reality in South Africa', Mail and Guardian, 10 October. Available at: https://mg.co.za/thought-leader/opinion/2022-10-10-mental-health-for-all-is-not-a-reality-in-south-africa/
[174] Moodley SV, Wolvaardt J, Grobler C. Knowledge, confidence, and practices of clinical associates in the management of mental illness. S Afr J Psychiatr. 2023 Oct 26;29:2074. doi: 10.4102/sajpsychiatry.v29i0.2074. PMID: 37928935; PMCID: PMC10623624.

In response to these shortages, provincial departments of health have initiated plans and targets to bolster mental health staff recruitment to ensure access to quality care.

Investments in staff provisioning

The 2021/2022 Annual Department of Health Western Cape report outlines plans to strengthen mental health services in George with an additional social worker at George Regional Hospital. Paarl will gain a psychologist, the West Coast a social worker and nurse, and Worcester will receive extra staff to address underserved areas in the Cape Winelands and Overberg districts (Western Cape Department of Health, 2022)[125].

Under the National Health Insurance (NHI conditional grant which allocates funding towards mental health) the Western Cape Department of Health achieved most of its staff acquisition goals in 2021/2022, as outlined in their service provisioning and staff goals. Patients screened and patients receiving treatment, along with outpatient reviews at Valkenburg, fell below the set targets.

KwaZulu-Natal has introduced 7 new programmes aimed at improving mental health services. These programmes include: one Advanced Diploma in Midwifery and six Post Graduate Diplomas: Mental Health Nursing, Neurology Nursing, Critical Care Nursing (Adult), Perioperative Nursing, Primary Care Nursing and Midwifery are being evaluated by accreditation bodies (KwaZulu-Natal Department of Health,2022)[175] .

In the Northern Cape, efforts have been made to strengthen HR capacity within the mental health sub-directorate, addressing previous shortages. In Pixley ka Seme, the appointment of mental health coordinators has addressed previous deficiencies. Additionally, a child and adolescent mental health services ward has been operationalised to increase access to mental health services for these individuals. Despite the general staff shortages across the board, particularly in district mental health coordination, initiatives such as resuming outreach programme in the Sol Plaatjies municipality area aim to extend support province-wide and revive similar outreach efforts (Northern Cape Department of Health, 2022)[124].

Under the NHI conditional grant Limpopo made significant progress in 2021/2022. They achieved most of their staff recruitment targets and exceeded their goals for screening and treating patients. They fell short of their target for improving forensic evaluation backlogs, completing only 10 evaluations against a target of 500 (Limpopo Department of Health, 2022)[176].

TASK-SHARING AND TASK-SHIFTING

Task-sharing involves the strategic reallocation of tasks typically provided by specialist mental health workers (e.g., psychiatrists, psychologists) to health workers without specialised training in mental health, to increase access to mental health services. Task-sharing is not a new concept for the South African healthcare system; it

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175 KwaZulu-Natal Department of Health. (2022). Department of Health Annual Report (2021/2022). Available at: https://www.kznhealth.gov.za/2021-2022-annual-report.pdf

176 Limpopo Department of Health. (2022). Department of Health Annual Report (2021/2022). Available at: https://provincialgovernment.co.za/department_annual/1209/2022-limpopo-health-annual-report.pdf

was originally developed and successfully implemented to address the severe workforce shortage limiting the scale up of antiretroviral therapy and other HIV services (Jacobs et. al, 2021)[177].

Provinces are urged to ensure that generalists, nurses, and community health workers are trained in task-shifting approaches for the delivery of mental healthcare, including care for children and adolescents. Private providers may also be engaged where psychiatrists are unavailable in the public health system (Stein et.al, 2022)[178].

Efforts are underway to train community lay workers and nurses in task-sharing approaches, with HIV counsellors already providing mental health counselling services under specialist supervision (Stein et.al, 2022)[179].

Task shifting has been seen to improve productivity by utilising psychology undergraduates, equipping various healthcare cadres to address common mental disorders, and fostering intersectoral collaboration (Stein et. al, 2022)[178].

While task-sharing has shown productivity benefits, successful implementation hinges on thorough training, ongoing supervision, and ensuring the presence of dedicated mental health staff at primary healthcare levels. Despite its utility, task-sharing faces challenge such as workforce overcommitment, policy barriers, and the need for professional recognition and guidelines to address accountability issues (Stein et.al, 2022)[178].

The advancement of task-sharing in mental healthcare is propelled by several enabling factors, leveraging resources and technological innovations, while significant inhibitors hinder its effective integration, presenting formidable challenges (Stein et.al, 2022)[178].

[177] Jacobs Y, Myers B, van der Westhuizen C, Brooke-Sumner C, Sorsdahl K. Task Sharing or Task Dumping: Counsellors Experiences of Delivering a Psychosocial Intervention for Mental Health Problems in South Africa. Community Ment Health J. 2021 Aug;57(6):1082-1093. doi: 10.1007/s10597-020-00734-0. Epub 2020 Nov 8. PMID: 33161458; PMCID: PMC8217044.
[178] Stein DJ, Wolvaardt GG, Zungu N, Shisana O. Ten game-changers in mental health for South Africa. S Afr J Psychiatr. 2023 Nov 6; 29:2180. doi: 10.4102/sajpsychiatry. v29i0.2180. PMID: 38059195; PMCID: PMC10696531.

Figure28: Enablers and barriers to effective integration[178]

ENABLERS

- Abundance of psychology graduates capable of transitioning into clinical roles
- Presence of registered counsellors, though underutilised due to employment issues
- Availability of post-graduate diploma bridging courses for psychology graduates
- Technological advancements improve screening efficiency and effectiveness
- Algorithm-driven tools enable mid-level and lay workers to provide interventions for common mental health disorders
- Referral applications reduce workforce burden and can be implemented and low cost
- Successful training programs for community health workers and emergency medical workers in screening and interventions

INHIBITORS

- Public protectionist policies restrict scope of practice for mental health graduates and lower-level workers
- Limited public sector budget reduces funding for registrar positions
- Brain drain contributes to shortages in mental health staff
- Historical inadequacies in human resources for health policies hinder integration of mental health into primary and community packages
- Reluctance in public sector to employ lay workers due to career path limitations.
- Insufficient long-term support services and rehabilitation options
- Concerns regarding nurses' capacity and environment for effective screening due to inadequate knowledge and emotional readiness

The transition to task-sharing in mental health care underscores the necessity of evaluating the competencies of different healthcare professionals. Discussion in the "training gaps" section highlights deficiencies in mental health knowledge and treatment skills among community health workers (CHWs) and other professionals. It suggests integrating specific training in mental disorders screening for CHWs. Successful implementation hinges on recognising shared scopes of practice and resolving accountability issues.

KEY STRUCTURES WITHIN DISTRICTS

Each province is required to establish a Mental Health Directorate. As advised by the Mental Health Investment Case report the Mental Health Directorate should include: a director, four deputy directors, one assistant director, one technical advisor (advanced psychiatric nurse), one information system officer, one data analyst, one senior administration officer and one personal assistant to the director.[2] More generally, a key NDoH stakeholder[13] interviewed indicated that the composition of the Directorate is determined by the job description that is informed by a number of factors including the population figures of the province and the provinces' specific need etc. Based on 2017 information, three out of the nine provinces have established Mental Health Directorates, with a lack of resourcing and capacity cited as an inhibitor to achieving this (SAHRC)[120].

The National Mental Health Policy Framework and Strategic Plan[2] also proposes the introduction of district specialist mental health teams which should exist in each district. These teams are responsible for organising mental health and service delivery in their respective districts, however in 2017 only 11 DSMHTs have been appointed across four provinces, primarily due to budget constraints (SAHRC, 2017)[120]. Gauteng province has also additionally established clinical teams and NGO compliance teams to improve clinical care and governance in the mental health system (South Africa. Gauteng Department of Health, 2019)[104].

Figure 29: Organogram of mental health task teams as per Gauteng Mental Health Plan [104]
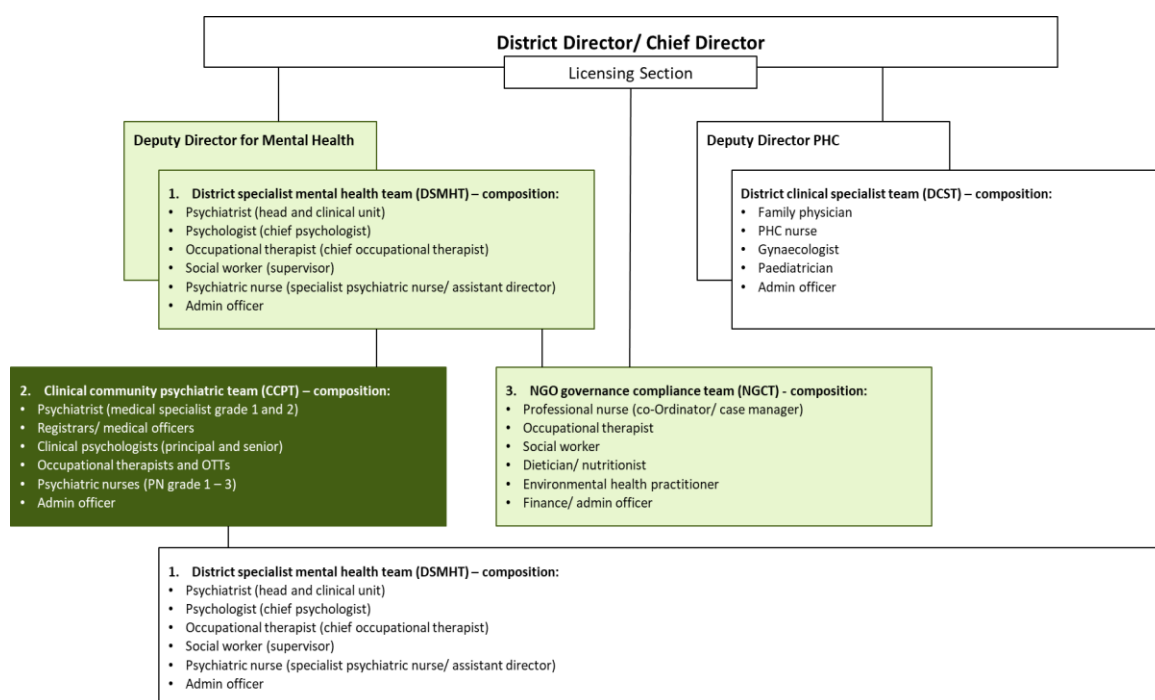
In Gauteng (Gauteng Department of Health, 2022)[104], well-established district teams manage mental health services efficiently. Tshwane alone has over 20 psychologists, each responsible for 2-3 sub-districts. Across 72 clinics, a multidisciplinary team comprising occupational therapists, psychologists, registered nurses, and social workers provides basic mental health services, with specialised care available at 65 clinics. Additionally, 3 NGOs teams cover multiple districts, collaborating with clinic nurses to ensure patient treatment and supporting NGOs in delivering community services.

In response to the Life Esidimeni case, Gauteng province established the **Mental Health Technical Advisory Task Team (MHTAT)** in 2018 (Gauteng Department of Health, 2022)[104]. Comprising experts from various mental health disciplines, the MHAT assesses gaps, implements recommendations, and enhances care quality through monthly meetings. It operates as a subcommittee of the Gauteng Department of Health's executive management committee, known as the **Gauteng Mental Health Technical Advisory Subcommittee (MHTAC).** The MHTAT's work is organised into specialised subcommittees focussing on strategic planning, institutional capacity building, integration of care, and human resources development. These subcommittees enable focused efforts on specific areas of improvement, leveraging interdisciplinary expertise to drive sustainable enhancements in mental health care delivery.

The Mental Health Review Boards (MHRBs), mandated by the Mental Health Act 2002, play a critical role in overseeing the care, treatment, and rehabilitation services provided to Mental Health Care Users (MHCUs). Their responsibilities encompass reviewing appeals against decisions made by health establishment head regarding assisted or involuntary mental health care, treatment, and rehabilitation services. MHRBs are tasked with making decisions on these services, conducting reviews on individual cases, considering 72-hour

assessments, and evaluating applications for transfers to maximum security facilities. They also review periodic reports on mental health status of mentally ill prisoners (Gauteng Department of Health, 2022)[104].

In 2017, the Human Rights Council noted in their investigative report thatMHRBs in six of the nine provinces were rated as 'poor' by the department's own assessment, except for the Western Cape, which was just noted to be poorly resourced (South African HRC, 2017)[120]. Subsequently, a key NDoH stakeholder interview[13] noted all provinces have established Mental Health Review Boards, connecting all healthcare facilities offering care, treatment, and rehabilitation services to these boards. However, challenges persist regarding the resourcing of these boards, including constraints such as limited office space and insufficient secretariat support.

FINANCIAL RESOURCES

South Africa's expenditure on mental health remains a critical aspect of its healthcare budget, accounting for 5% of the total healthcare budget in the 2016/2017 financial year (Docrat et. al, 2019)[17]. Significant disparities exist among provinces regarding funding distribution and resource allocation (Docrat et. al, 2019)[17]. The National Treasury's assessment reveals substantial annual spending of R5 billion on psychiatric hospitals, with additional funding estimated at R1 billion for mental health services at the primary healthcare level in 2016/2017 financial year (Docrat et. al, 2019)[17].

More recent data from the 2020/2021 Vote 18 health document shows that mental health service as well as oncology services falling under district health programmes for communicable and non-communicable disease programmes have now been allocated an additional funding through the NHI conditional grant. The mental health conditional grant allocation is being used by the provinces to complement the mental health human resources at primary health care by contracting psychiatrists, psychologists, occupational therapists, social workers and registered counsellors to strengthen access to mental health at primary health care level. The contracted professionals are also assisting with forensic mental observations backlog which is a key goal under the NHI conditional grant. This has resulted in a R299.4million increase to the baseline over the medium term to the National Health Insurance programme. At a provincial level, R2.1 billion is allocated to provincial health departments through the direct national health insurance grant for contracting primary care doctors, mental health and oncology service providers [179].

In 2016/2017 South Africa spent 5% of its healthcare budget on mental health. Gauteng (6.7%), KwaZulu-Natal (5.5%) and Western Cape (7.7%) spending more than this 5% average and Mpumalanga spending the least at 2.1% of its health budget in 2016/2017 (Docrat et. al, 2019)[17]. The National Treasury assessment revealed that during the 2016/2017 financial year, South Africa's expenditure on psychiatric hospitals amounted to a substantial R5 billion annually (Docrat et. al, 2019)[17]. At the PHC level, the estimated spending on mental health services was around R1 billion per annum. However, there were notable discrepancies in funding distribution among provinces (Docrat et. al, 2019)[17].

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[179] National Treasury, (2020/2021). ;Vote 18'. Available at: https://www.treasury.gov.za/documents/national%20budget/2022/ene/Vote%2018%20Health.pdf

Provincial departments are responsible for developing budgets for mental health care in South Africa. These budgets allocate funds to various components such as inpatient and outpatient services, community-based organisations (CBOs), and non-governmental organisations (NGOs). There is a significant disparity in allocation, with only 7.9% of the total mental healthcare budget directed towards outpatient services at primary care level and 0.2% towards mental health centres, leaving community-based organisations (CBOs) and non-governmental organisations (NGOs) under resourced (Docrat et. al, 2019)[17]. This is especially relevant where we see most of the population accessing care at the primary healthcare levels.

Provinces often lack detailed strategic plans for mental health or a lack of planning for mental health is observed in their national strategies hindering the implementation of the National Mental Health Policy and Framework (SAHRC, 2017)[120]. In the SAHRC investigative hearing of 2017, no province could provide a detailed budget for mental health, particularly for community-based mental health service provisioning, except for Gauteng which allocated about R224 375 700 or 19% of the total mental health budget to primary healthcare (SAHRC,2017)[120]. According to publicly available information, only Gauteng[104] Northern Cape[180], Western Cape[181] and KwaZulu-Natal[182] have strategic plans for mental health care service delivery developed. However, the NDoH stakeholder interviewed in this project has noted that the Free State also has a strategic plan developed[13].

Besides state funding, many programmes receive funding from international aid and donor organisations such as the Bill and Melinda Gates Foundation, PEPFAR, the Global Fund, The Welcome Trust and others. These funds are often ring-fenced for mental health and often come with their own sets of caveats which need to be met compared to government funding which is provided in a lump-sum to provinces who then need to allocate it according to their needs.

The lack of appropriate budgeting within provinces has resulted in an inefficient use of resources. One key example of inefficient resource use is highlighted in readmission costs amounting to approximately USD112.6 million/18.2% of total national mental health budget (Docrat et. al, 2019)[17]. Additionally, re-admission cost for mental health patient varies across different levels of care, with specialised psychiatric hospitals, incurring the highest costs.

Table 10: Re-admission costs of MH patients by hospital level in 2016/2017[17]

LEVEL OF CARE	RE-ADMISSION RATE	RE-ADMISSION COST (USD, 2016/2017 FINANCIAL YEAR)
District Hospitals	21.6%	11.9 million
Regional Hospitals	29.9%	21.24 million
Tertiary Hospitals	29.3%	13.2 million
Central Hospitals	5.6%	2.3 million

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[180] Northern Cape Department of Health. (2023). 'The provincial mental health strategic plan 2023-2030'
[181] Western Cape Department of Health. (2014). 'Healthcare 2030 The Road to Wellness' Available at:
https://www.westerncape.gov.za/assets/departments/health/healthcare2030.pdf
[182] KwaZulu-Natal Department of Health. (2007). 'KwaZulu-Natal Treatment Protocols for Mental Health Disorders' Available at:
https://www.kznhealth.gov.za/townhill/protocol.pdf

LEVEL OF CARE	RE-ADMISSION RATE	RE-ADMISSION COST (USD, 2016/2017 FINANCIAL YEAR)
Specialised Psychiatric Hospitals	25.5%	63.9 million

This shows that there is scope for redistributing funds across different service levels to make more efficient use of funding. The main cause of re-admissions was cited as inappropriate referrals, patients being released too early or with inappropriate community/at-home planning for the transition back (Docrat et. al, 2019)[17].

This same study looked at in-patient and out-patient mental health costs in the public sector by province in 2016/2017. Results are included in Table 11. At a national level USD492.1 million was spent on in-patient care with provinces such as Gauteng, KwaZulu-Natal and the Western Cape spending USD100 million and more per province on in-patient care. Provinces such as the Free State, Mpumalanga and Northern Cape spending substantially less, with Mpumalanga spending less than 1/10th the amount spent by Gauteng and KwaZulu-Natal (Docrat et. al, 2019)[17]. In-patient care was by far the greatest cost driver with a national out-patient spend of only USD81.5 million (six times less than in-patient spend) (Docrat et. al, 2019)[17]. Outpatients spend was highest for the same provinces as in-patient spend (Gauteng with USD18.8 million, KwaZulu-Natal USD23.8 million and the Western Cape with USD10.5 million) with the Free State (USD2.2 million), Northwest (USD3 million) and the Northern Cape (USD2.3 million) spending substantially less (Docrat et. al, 2019)[17].

Total inpatient and outpatient spending per capita (uninsured population) was highest for Gauteng (USD17.1), KwaZulu-Natal (USD14.1) and the Western Cape (USD12.4) – the provinces who also spent the most overall on inpatient and outpatient services (Docrat et. al, 2019)[17]. The lowest per capita spend was reported in Mpumalanga as (USD3.5) followed by Limpopo (USD5.9). These are the two provinces which are also lacking in infrastructure, facilities and human resources (Docrat et. al, 2019)[17].

Table 11: Provincial and national summary of total costs by mental health services in 2016/2017[17]

MEASURE	EC	FS	GT	KZN	LP	MP	NC	NW	WC	National
Inpatient cost of mental health services (USD, millions)	50.8	16.4	152.9	110.8	21.8	10	10.7	18.8	100	492.1
Outpatient cost of mental health services (USD, millions)	8.5	2.2	18.8	23.8	9.3	3.1	2.3	3	10.5	81.5
Total inpatient and outpatient mental health service cost (USD, millions)	59.3	18.6	171.6	134.7	31.1	13.1	13	21.8	110.6	573.6

MEASURE	EC	FS	GT	KZN	LP	MP	NC	NW	WC	National
Total inpatient and outpatient mental health expenditure per capita (Uninsured; USD)	9.7	7.8	17.1	14.1	5.9	3.5	12.9	6.7	22.1	12.4
Proportion of 2016/17 health budget spent on mental health inpatient and outpatient services (%)	4.00%	2.80%	6.20%	5.00%	2.60%	1.70%	3.90%	3.10%	7.50%	4.60%
Total transfers for contracted hospital services for mental health (USD, millions)	8.9	No information (NI)	NI	11.3	NI	3.1	NI	NI	NI	23.3
Total DOH transfers to mental health NGOs (USD, millions)	0.8	0.2	13.7	1	NI	NI	NI	NI	2.7	18.4
Total costs of inpatient and outpatient mental health services and transfers to contracted hospitals and NGOs for mental health services (USD, millions)	69	18.7	185.3	147	31.1	16.1	13	21.8	113.3	615.3
Total costs of inpatient and outpatient mental health services and transfers to contracted hospitals and NGOs for mental health services per capita	11.3	7.9	18.5	15.4	5.9	4.3	12.9	6.7	22.6	13.3

MEASURE	EC	FS	GT	KZN	LP	MP	NC	NW	WC	National
uninsured (USD)										
Proportion of 2016/17 health budget spent on mental health inpatient and outpatient services and transfers to contracted hospitals and NGOs (%)	4.60%	2.80%	6.70%	5.50%	2.60%	2.10%	3.90%	3.10%	7.70%	5.00%

While it is useful to draw comparisons, we need to understand the base of the mental health funding – which is essentially the healthcare financing provinces are allocated by national government. Assessing how much of the health budget allocated per province went to mental health care reveals that Gauteng (6.2%), KwaZulu-Natal (5.0%) and the Western Cape (7.5%) are prioritising mental health and contributing above the national average proportion, whereas provinces such as the Eastern Cape (2.8%), Limpopo (2.6%) and the Northwest (3.1%) allocate a smaller proportion of their health budget towards mental health (Docrat et. al, 2019)[17]. There are varying reasons this could be the case.
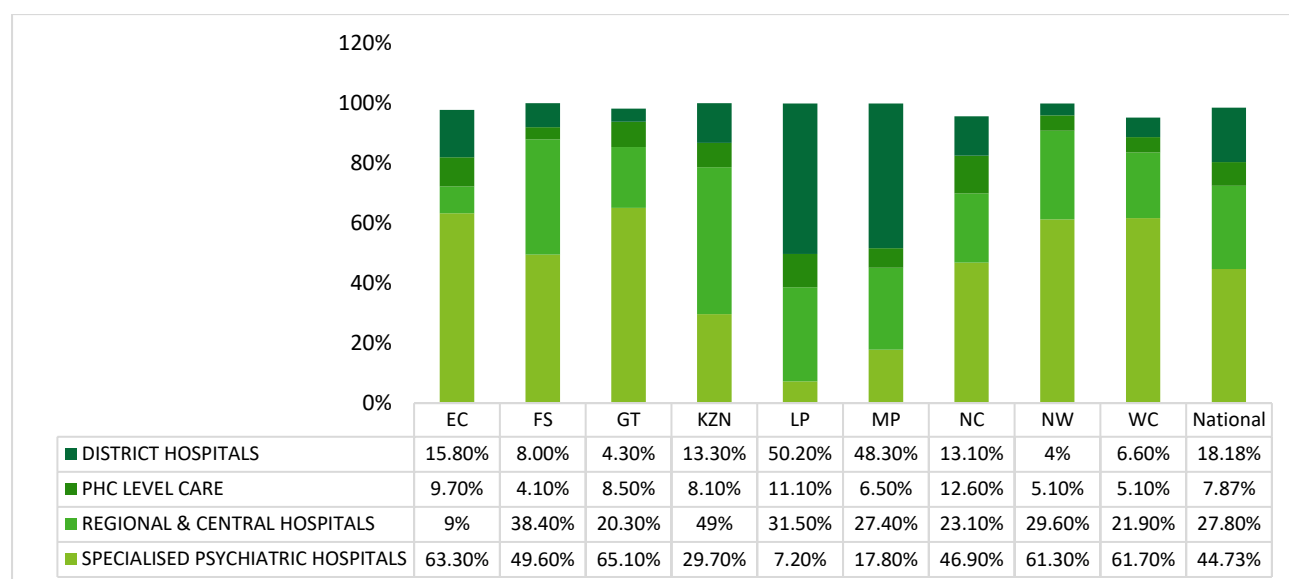
With respect to transfers from department of health for contracted hospitals, information on costs was only shared by Eastern Cape, KwaZulu-Natal and Mpumalanga with the other provinces failing to share information. Across these three provinces, KwaZulu-Natal contributed the most (USD11.3million), followed by Eastern Cape (USD8.9million) and Mpumalanga (USD3.1million). Similarly for transfers from department of health to mental health NGOs, provinces such as Limpopo, Mpumalanga, Northern Cape, and Northwest did not share data. Across the provinces who did share data, Gauteng contributed the most (USD13.7 million) compared to Western Cape (USD2.7 million), Eastern Cape (USD0.8 million) and Free State (0.2 million) (Docrat et. al, 2019)[17].

When assessing the total spent taking into consideration these transfers, a similar picture prevails where Gauteng (USD18.5 million), KwaZulu-Natal (USD15.4million) and Western Cape (USD22.6million) spend the most (Docrat et. al, 2019)[17]. Provinces such as Limpopo (USD5.9 million), Mpumalanga (USD4.3million) and the Northwest (USD6.7million) continue to spend the least overall on mental health (Docrat et. al, 2019)[17].

Figure 30 shows disaggregation of provincial spend on mental health across the different levels of healthcare. This figure show that the majority (six out of nine) provinces focus on funding specialised mental health care with the majority of budget going towards specialised care with Limpopo, Northwest and KwaZulu-Natal as the exceptions (Docrat et. al, 2019)[17]. For Limpopo and Mpumalanga, district hospitals receive the greatest share of

the mental health budgets and for KwaZulu-Natal, it is the regional and central hospitals receiving the greatest share (Docrat et. al, 2019)[17].

Figure 30: Disaggregated provincial spend for mental health across level of care in 2016/2017[17]

	EC	FS	GT	KZN	LP	MP	NC	NW	WC	National
■ DISTRICT HOSPITALS	15.80%	8.00%	4.30%	13.30%	50.20%	48.30%	13.10%	4%	6.60%	18.18%
■ PHC LEVEL CARE	9.70%	4.10%	8.50%	8.10%	11.10%	6.50%	12.60%	5.10%	5.10%	7.87%
■ REGIONAL & CENTRAL HOSPITALS	9%	38.40%	20.30%	49%	31.50%	27.40%	23.10%	29.60%	21.90%	27.80%
■ SPECIALISED PSYCHIATRIC HOSPITALS	63.30%	49.60%	65.10%	29.70%	7.20%	17.80%	46.90%	61.30%	61.70%	44.73%

On average across the nine provinces, PHC receives the lowest contribution from the total mental health budget, followed by district hospitals (Docrat et. al, 2019)[17]. Provinces such as Gauteng, KwaZulu-Natal, Limpopo and the Northern Cape contribute more to PHC levels when compared to the national average (Docrat et. al, 2019)[17]. Limpopo and Mpumalanga also contribute more to the district hospitals when compared to the national average (Docrat et. al, 2019)[17]. This could be because of Limpopo and Mpumalanga not having many or any specialised hospitals within in their province.

To supplement these findings and understand how these trends have changed over time, the annual reports (2021/2022) of all nine provinces were analysed. The table below shows the total mental health spending for each province. Based on these results, Gauteng, Western Cape and KwaZulu-Natal spend the most which aligns with results from Docrat et. al (2019). Provinces such as Mpumalanga, Northwest, Eastern Cape and Northern Cape spend the least which paints a similar picture to 2016/2017 data.

Table 12: Mental health spending across provinces in 2021/2022 (R'000) [183, 184,122, 176,177,123, 124, 185, 125]

2021/2022	EC	FS	GA	KZN	LP	MP	NC	NW*	WC
Spend on psychiatric mental hospitals ('000)	554,702	364,882	1,669,528	1,00,4377	580,362	43,594	123,254	558,019	1,073,505

*2020/2021 results used as 2021/2022 was not available

Source: Annual Department of Health Reports across all nine provinces.

The Department of Basic Education (DBE) also stated that in 2016/2017 special schools will receive additional non-teaching support staff to *'ensure the safety and dignity of learners with severe disabilities in special school hostels'*, with a budget from 2018 to 2021 of R9,031,157,000 (SAHRC,2017)[120].

The Western Cape, allocated R66,728 towards NPOs across different districts (Western Cape Department of Health, 2022)[186]. In Gauteng this number was R226,997 however only R193,643 was used due to many users not returning to institutions because of Covid-19 (Gauteng Department of Health, 2022)[104].

The most cited recommendations for improving financing in mental health involve enhancing the efficiency of existing resources by better aligning human resource posts and budgets with workload, reviewing hospital platforms to support shorter lengths of stays and increased outpatient care, and reallocating budgets to ensure underutilised existing facilities become fully operational rather than investing in new ones.

Funding received by NGOs/CBOs:

The level of reporting of budget allocation to mental health NGOs and CBOs varies across provinces with some provinces reporting the NGOs and exact amounts allocated to each NGO. Other provinces do not report on their NGO and CBO funding allocation and only report the psychiatric mental health hospitals expenditure. We assume that provinces who have established mental health spending plans will have more granularity in annual audits of how this funding is spent.

The major funders for NGOs and CBOs in South Africa are World Federation for Mental Health, United for Global Mental Health, UNICEF, various government departments such as the Department of Health, Department of Social Development, Department of Education and others. The National Department of Health spent R67,329 million on transfers to NPOs and NGOs. In 2022/2023 the South African Federation of Mental Health received R488,000 (<1% of total) from the National Department of Health for implementation activities up from the

[183] Eastern Cape. Department of Health. (2022). Department of Health Annual Report (2021-2022). Available at: https://provincialgovernment.co.za/department_annual/1154/2022-eastern-cape-health-annual-report.pdf
[184] Free State. Department of Health. (2022). Department of Health Annual Report (2021-2022). Available at: https://provincialgovernment.co.za/department_annual/1168/2022-free-state-health-annual-report.pdf
[185] Northwest Department of Health. (2021). Available at: https://provincialgovernment.co.za/department_annual/1059/2021-north-west-health-annual-report.pdf
[186] Western Cape Department of Heath. Department of Health. (2023). Department of Health Annual Report (2022-2023). Available at: https://provincialgovernment.co.za/department_annual/1427/2023-western-cape-health-and-wellness-annual-report.pdf

previous year's R459,000 (National Department of Health, 2023)[187]. Other similar organisations such as LifeLine received R28,875 in 2022/2023 (NDoH, 2023)[189]. Annual reports from the South African Federation for Mental Health show they made an operating loss of R1,237,067 in 2023, an increased loss from the operating loss made in the year before R694,905 (SAFMH, 2023)[188]. Similarly, LifeLine Pretoria's 2020 financial statements indicate that operating losses have been made in 2018/2019 and 2019/2020 (Lifeline, 2021)[189]. NGOs receiving government funding noted in 2017, that the subsidies of R2,278 to R2700 per patient provided per month did not cover the costs (Business Day, 2017)[190].

RETURN ON INVESTMENT FOR MENTAL HEALTH PROGRAMMES

In 2019, the National Department of Health commissioned an Investment Case for Mental Health. Developing this case would provide a clear quantification of and case for investment to transform South Africa's mental health services in line with international and local evidence by estimating the return on investment (ROI). The ROI was estimated over a 15-year period and focused on scaling up interventions targeting anxiety, depression, psychosis, bipolar disorders, epilepsy and other behavioural and substance-use disorders (Besada, Docrat and Lund, 2021)[191]. The ROI also estimated and extrapolated resources required for (1) early interventions for those exhibiting risky alcohol and substance-use behaviours and (2) the development and roll-out of social-emotional learning programmes delivered in schools to learners (aged 12–17 years) (Besada, Docrat and Lund, 2021)[193]. This investment case was a collaborative effort across multisectoral, national and sub-national structures including clinicians, academic experts, service providers and national treasury (Besada, Docrat and Lund, 2021)[193]. This was done to ensure both clinical and financial views were appropriately included in the exercise.

The investment case made use of the WHO Inter-UN OneHealth Tool along with an excel based model to cost treatment and rehabilitation interventions and their expected health benefits. The total economic and social value of the health benefits are then estimated; to determine benefit-cost ratios for each package of interventions. While the quantification for investment is important, this case also considered non-quantitative elements such as investing in mental health for human rights protection, equality of access and efficiency to formulate a more robust case for investment (Besada, Docrat and Lund, 2021)[193].

The investment case proposed a model for both community day care and residential services. The model is disability inclusive and proposes care be delivered through a framework which tackles poverty and reintegrating individuals into their community. Such an approach relied heavily on occupational therapists with a core package of community-based services including: (1) residential and day care service through collaborative efforts with the DSD and NPO, (2) psychosocial and rehabilitation services, (3) mental health literacy and self-care, (4)

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[187] National Department of Health. (2023). Annual Report (2022/2023). Available at: https://www.gov.za/sites/default/files/gcis_document/202310/health-annual-report.pdf
[188] South African Federation of Mental Health. (2023). Annual Report. Available at: https://www.safmh.org/wp-content/uploads/2023/09/SAFMH-Annual-Report-V4.pdf
[189] Lifeline South Africa. (2021). Annual Report 2020. Available at: https://lifelinepta.org.za/wp-content/uploads/2021/09/LifeLine-Pretoria-Financial-Report-2020.pdf
[190] Business Day. (2017). Mental health NGOs struggle with inadequate subsidies. Available at: https://www.businesslive.co.za/bd/national/health/2017-10-17-mental-health-ngos-struggle-with-inadequate-subsidies/
[191] Besada, D., Docrat, S., Lund, C. (2020). South Africa Mental Health Investment Case. National Department of Health: South Africa.

medication adherence support, and (5) capital investments through the Department of Human Settlements in alignment to their special housing policy The approach focused on collaborative and coordinated implementation and funding efforts across all government departments from DoH to Department of Social Development and the Department of Education (Besada, Docrat and Lund, 2021)[193].

Lost days of work on account of illness and premature mortality according to each MNS disorder in South Africa have been estimated, after accounting for unemployment and labour force participation. Lost days of work was estimated using local data on different MNS disorders from Mall et. al (2015) which was determined through the South African Stress and Health Study (SASH) as well as WHO World Mental Health Surveys. The economic value of lost days of production amounts to 2.4 trillion (1.9 trillion NPV), estimated at a yearly average of ZAR 161 billion; this equates to approximately 4% of the country's GDP. The combined economic value of this lost productivity greatly exceeds the estimated cost of current mental health expenditure and the projected service scale-up. A net return on investment of $5.08 for every $1 invested in a school-based mental resilience programme was estimated (Besada, Docrat and Lund, 2021)[193].

While there has been some work to explore alternative financing options for mental health in South Africa much more is still needed. To undertake sustainable financing for mental health the Emerald Framework[192] for sustainable mental health financing indicates that a country would need to undertake an: (1) assessment of the public health consequences of mental disorders; (2) assessment of the private and public economic consequences of mental disorders; (3) assessment of projected resource needs for scaling-up mental health services; (4) assessment of the mental health and general health system; (5) assessment of the current and projected macro-fiscal situation, and finally (6) assessment and selection of appropriate financing mechanisms.

Gauteng stopping funds to NGOs use case (Vulekamali, 2023)[193]

On the 5th of April 2023, the Department of Social Development announced that there would be funding cuts across various parts of the Gauteng NPO sector with immediate effect. These cuts included:

- Programme 1: Administration is reduced from R753,449,000 to R718,409,000 (R35 million decrease)

- Programme 2: Social Welfare Services Reduced from R1,050,199,000 to R692,604 (R357 million decrease)

- Programme 3: Children and Families decreases from R2,151,638,000 to R1,965,543,000 (R220 million decrease)

- Programme 4: Restorative Services increased from R760,036,000 to R959,904,000 (R200 million increase)

- Programme 5: Development and Research got a shocking sharp increase from R821,904,000 to R1,214,346,000 (R392 million increase)

Since then, some organisations have received service level agreements indicating cuts in funding of between 60-100% leaving programme beneficiaries and employed staff with their lives disrupted. The impact of these cuts

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192 Alan J Fisher Centre for Public Mental Health. (n.d.). EMERALD: Emerging Mental Health Systems in low- and middle-income countries. Available at: https://cpmh.org.za/research-2/emerald/
193 Vulekamali. (2023). Social Development National Department Budget for 2022 – 2023. Available at: https://vulekamali.gov.za/2022-23/national/departments/social-development/

was estimated to affect 10,000 beneficiaries leaving them exposed to neglect, exposure, abuse, and a loss of life purpose. Vaal Mental Health received a 61% funding cut leaving their support groups in Sebokeng and Vanderbijpark with 4000 people without services. Laudium Mental Health was more severely impacted experiencing a 100% cut in funding leaving 100 beneficiaries unmonitored. The director of the North Gauteng Mental Health indicated that their 1000+ beneficiaries will be left without access to vital services. Across all these institutions it was noted that staff at these facilities will also suffer as they lose their employment.

On 9 April 2023, the Gauteng department of social development indicated that the overall R2.3 billion budget (the highest across all South African provinces) for NPOs was not being cut but reconfigured to respond to identified priorities by Gauteng's premier such as substance abuse treatment, homelessness, empowerment programmes and food security. NPOs disagree with this decision as many of their programmes are cross-functional and interlinked, covering said priorities. Additionally, NPOs were not consulted or advised about this decision and simply informed which goes against the mandate of treating NPOs as partners in decision-making (SAFMH, 2023; Pongweni & Clark, 2023 and Nt'sekhe, 2023) [194,195,196].

More updated information from the Gauteng Department of Social Development would be useful to understand the current state of NGO funding.

OPPORTUNITIES FOR COLLABORATIONS BETWEEN PUBLIC AND PRIVATE PROVIDERS

South Africa experiences significant human resource constraints of mental health care practitioners. Given the limited number of staff, innovation in mental health service delivery needs to be considered. There is significant variation in the staffing across provinces for mental health care. Suggestions have been made to make use of community service graduates, particularly those in rural areas as well as increasing public private partnerships to make use of their staff platforms, and technologies such as telemedicine (SAHRC,2017)[120].

The South African Society of Psychiatrists reported that in October 2020, 785 psychiatrists were registered with the HPCSA. However, not all of these are active practitioners (Kagee et. al, 2022)[197]. Over 84% of psychiatrists are based in three provinces: Gauteng (302), Western Cape (251) and KwaZulu-Natal (209) and 73% of psychiatrists work in the private sector (Kagee et. al, 2022) [199]. While the inequitable distribution of psychiatrists is a key consideration, by drawing on psychiatrists in the public and private sectors, this combined workforce would result in an estimated ratio of psychiatrists to population of 1.3 psychiatrists per 100 000 (Kagee et. al, 2022)[199] higher than the current ratio of less than 1.

Additionally, National Treasury has set aside funding to support the country in meeting its National Development Plans through funding the development of a stronger more competitive infrastructure base. By using public-

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[194] South African Federation for Mental Health. (2023). 'SA Federation for Mental Health Condemns Gauteng DSD's Cessation of Funding to NPOs', SAFMH Newsroom, 20 April. Available at: https://www.safmh.org/sa-federation-for-mental-health-condemns-gauteng-dsds-cessation-of-funding-to-npos/

[195] Pongweni, T., and Clark, W., (2023). 'What about the children, the disabled, the mentally ill?" NPOs blast Gautengs reconfigured social welfare budget', Daily Maverick, 13 April. Available at: https://www.dailymaverick.co.za/article/2023-04-13-npos-blast-gautengs-reconfigured-social-welfare-budget/

[196] Nt'sekhe, R. (2023). 'Vulnerable lives compromised as DSD reduces NPOs' funding by R62,1 million', Politics Web, 13 April. Available at: https://www.politicsweb.co.za/politics/r621-million-less-for-gauteng-npos--refiloe-ntsekh

[197] Kagee, Ashraf & Docrat, Sumaiyah & Freeman, Melvyn & Lund, Crick & Phakathi, Sifiso & Shiba, Dudu & Thom, Rita. (2022). Mental Health.

private partnerships the rigour in project assessment and accountability will create opportunities to use private financing for public infrastructure projects. There are numerous working examples of public private partnerships which can be used to learn lessons of what works in this space:

Child Gauge Case Study (Tomilson, Kleintjies and Lake, 2022)[198]

The Gauge singled out a pilot project in the Khayelitsha Eastern Substructure in Cape Town, where child and adolescent-centric mental health services are provided in clinics in Khayelitsha. To increase the number of nurses who can provide mental health support, they have opened training to all nurses working in the KESS clinics. Children and adolescents (under 19 years) make up 33% (397 294) of the population. The data from the second quarter of this year (July to September), shows that in that period, there were 1 482 children younger than 1 who presented at their facilities for specialist mental health services. At Michael Mapongwane clinic, they have dedicated Thursdays to providing services only for children. Adults are seen on other days. On Thursdays, the number of children they see varies with an average of ten.

 "What we do is we separate follow-ups and new cases," says Nomayela. "New cases take time. A nurse can sit with one child for an hour and a half or more so that we get as much information as we can. Follow-up cases don't take so much time. We also book appointments based on who goes to school and who doesn't, and we try and prioritise those going to school or writing exams."

One of the interview participants noted that while the school based mental health programmes focus efforts on screening, once screened there is limited information on referring the child to the appropriate level of care.

Sanofi Case study (Szabo, Mayers and Fine, 2017)[199]

Recognizing the potential for mental health care professionals to provide leadership in transforming the health care environment and ensuring better access to care for their patients, the Department of Psychiatry at the University of the Witwatersrand (Johannesburg, South Africa) embarked on an innovative mental health leadership training programme conducted in the public mental health sector in collaboration with Sanofi South Africa. Selected participants included 15 mental health care professionals drawn from six public health care facilities nationally. The participants represented a range of disciplines, i.e., psychiatry, psychiatric nursing, occupational therapy and psychology. Each of the six project groups was assigned to one of three mentors, senior health care professionals with vast experience in the fields of psychiatry, public health and nursing. These mentors provided support, advice and encouragement on a regular and continuous basis. Aside from individual participant/mentor meetings all mentors and participants attended a 6-monthly workshop over a period of 2 years to report on project progress, share successes and tackle challenges. This project design enabled participants to exercise and test their learning in pursuit of a practical objective related to an aspect of their daily work.

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[198] Tomlinson M, Kleintjes S & Lake L (2022) *South African Child Gauge 2021/2022*. Cape Town: Children's Institute, University of Cape Town.
[199] Szabo, C.P., Fine, J., Mayers, P. *et al.* Mental health leadership and patient access to care: a public–private initiative in South Africa. *Int J Mental Health Systems* **11**, 52 (2017). https://doi.org/10.1186/s13033-017-0160-4

Digital Solutions

Healthcare across South Africa requires solutions that allow for innovations to revolutionise healthcare delivery models. Gijima is a healthcare digital technology equipping specialists, surgeons, healthcare workers and pharmacies with state-of-the-art patient-centric digital platforms (Gijima, n.d.)[200]. This tool allows for improved patient care, access to records, financial stability along with security. This tool is currently used in some facilities across Gauteng (Gauteng Mental Health Strategy and Action Plan 2019 – 2030)[104].

In the Western Cape, efforts have been made to develop a mental health dashboard which allowed PDoH to track adherence to treatment and consultations (Western Cape Department of Health, n.d.)[201]. A screenshot of the tool can be seen below.

Figure 31: Screenshot of healthcare dashboard developed in the Western Cape[202]
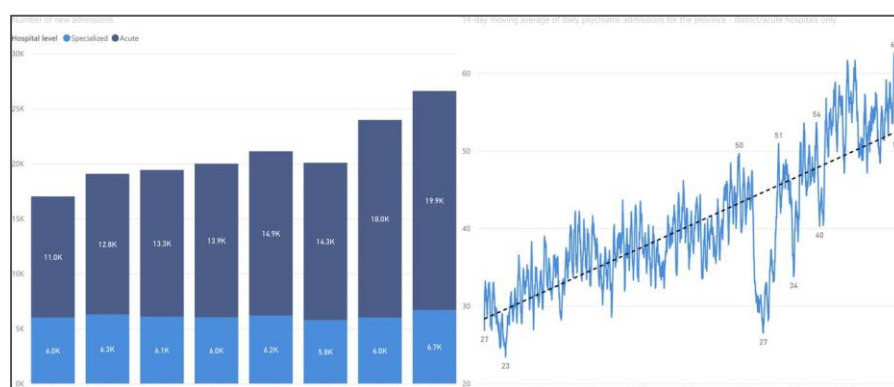
The Hospital Management System (version 2) has been initiated at the Elizabeth Donkin Hospital in the Nelson Mandela Bay this financial year. This system was developed during Covid-19 when the department had learnt to monitor patients remotely and used data to detect symptoms. The tool was developed in collaboration with the Nelson Mandela University which also provided basic digital literacy support refresher courses, training on the system and ongoing end-user support to ensure the hospitals self-sufficiently use the tool. This system will allow

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[200] Gijima, (n.d.). Available at: https://www.gijima.com/healthcare/
[201] Western Cape Department of Health, (n.d.). Available at: https://www.westerncape.gov.za/service/mental-health-services-western-cape

for patient tracking across different levels of the healthcare system which can be accessed across all facilities (Nelson Mandela University, 2021)[202] .

AitaHealth, is a locally developed mobile phone app used to capture and manage data of primary health care programmes. This app has been piloted in the City of Tshwane and the district office in Gauteng province. The primary care programme uses Ward Based Outreach Teams to provide services to individuals and families at the household level and are composed of professional nurses and community health workers (Strydom, 2017)[203]. These programmes focus on promoting health seeking behaviours amongst citizens and focuses on maternal and child health, HIV/AIDS, TB and non-communicable chronic diseases using AitaHealth to capture and monitor health data of households. The AitaHealth app has been used in Gauteng's Tshwane district as well as in the Free State's Thabo Mofutsanya district, the Gert Sibande district in Mpumalanga and the Umgangandlovo district in KwaZulu-Natal. The ward-based outreach teams in districts capture the household registration and assessment data on their mobile phones into the AitaHealth app. Based on the community outreach approach in Gauteng each CHW is assigned 250 households to provide services to. The teams are then able to use the data to plan and determine appropriate interventions for individuals and households. These reports and data are also shared with clinic managers who provide clinical support to outreach teams. Between September 2014 and June 2015, a total of 40 000 household health status assessments had been carried out, using AitaHealth. This figure increased to an impressive 150 000 by March 2017 (Strydom, 2017)[205].

Panda is a mental health support mobile app launched in 2021 to provide individuals with access to a supportive community where they can get treated. The app includes the ability to connect anonymously with experts and peers facing similar challenges, helps you objectively track and assess changes in your mental health, offers life skills training and chat support (Ebrahim, 2022)[204].

Using mobile or digital applications allow anyone, anywhere to get the support they need, in a more affordable, anonymous, and convenient way often acting as a first point of call for many suffering from mental health issues.

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[202] Nelson Mandela University. (2021). 'Province launches paperless patient management system', Mandela University in the NEWS, 18 October. Available at: https://news.mandela.ac.za/Mandela-University-in-the-NEWS/Mandela-University-in-the-NEWS-Archive/Province-launches-paperless-patient-management-sys

[203] Strydom, C. (2017). 'AitaHealth: When Technology and People Join Hands', Mezzanine. Available at: https://mezzanineware.com/aitahealth-when-technology-and-people-join-hands/

[204] Ebrahim, Z. (2022). 'This smartphone app is here to help tackle South Africa's mental health crisis', News24. Available at: https://www.news24.com/life/wellness/mind/this-smartphone-app-is-here-to-help-tackle-south-africas-mental-health-crisis-20221020-2

THEME 3 UNDERSTAND THE ROLE AND IMPACT OF POLICY AND REGULATION ON SERVICE PROVISIONING

OBJECTIVES FOR THEME 3:

Analyse the evolution of policy, legislative and regulatory frameworks between 1994 and 2023, assessing their impact on access to mental healthcare services.

The information presented in this theme will comprise a literature review of available information on policy development in South Africa, as well as information directly from policies.

South Africa's constitution mandates healthcare access for all citizens, with primary services provided at no cost in the public sector. The predominantly public healthcare system faces resource strain, leading to the implementation of government policies and guidelines for service provision. The first national policy reform occurred post-1994, aiming to ensure equitable access to quality services for all citizens (Draper et. al, 2009)[205].

South Africa has witnessed a significant policy evolution, transitioning from a historically fragmented approach to a more human centric, integrated, collaborative (community-based) and comprehensive strategy within the broader healthcare framework. This evolution reflects a growing recognition of the importance of addressing mental health concerns and aligning with international standards and frameworks.

THE EVOLUATION OF MENTAL HEALTH POLICIES IN SOUTH AFRICA

1994

Post-Apartheid (1994) marked the beginning of major political reforms, including in the field of mental health as South Africa's first democratically elected government was instituted. During this time government was committed to transforming the healthcare system from one that worked for some to one which sought to provide equitable and accessible care to all South Africans

1997

The 1997 Mental Health Policy Guidelines were crafted under the guidance of the National Director for Mental Health drawing on international policies and stakeholder consultations. Despite its comprehensive approach, **the guidelines lacked formal adoption protocols and were not widely disseminated.** One drawback was their emphasis on national-level guidelines, expecting provinces to develop their own policies, potentially leading to **inconsistency in implementation**. Additionally, they were intended to be read alongside other policies, such as the Child and Adolescent Mental Health Policy Guidelines.

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[205] Draper C.E., Lund, C., Kleintjes,S., Funk, M., Omar, M., Flisher, A.J. (2009).The MHaPP Research Programme Consortium, Mental health policy in South Africa: development process and content, Health Policy and Planning, Volume 24, Issue 5, September 2009, Pages 342–356. Available at: https://doi.org/10.1093/heapol/czp027

2002

The Mental Health Act No 17 of 2002 **prioritised protecting the human rights of individuals with mental disorders**. It **emphasised care, treatment and rehabilitation** on the least restrictive environments possible, closer to individuals' homes or communities. Unlike its predecessor, the Mental Health Act, of 2002 **focused more on users' experiences, ensuring their rights were upheld and care was tailored to their specific needs**, enhancing adherence. While, the content of the Mental Health Care Act (2002) aligned with the 1997 policy guidelines, the major difference lay in the development and approval process, with the new policy requiring adherence to subsequent protocol requirements (Draper et. al, 2009) [207].

2006

The first National Mental Health Policy Framework and Strategic Plan (MHPFSP) started its development process in 2006. Content of this policy was compiled through a desktop activity within the Department of Health and circulated for input to mental health stakeholders in the country in April 2006. A second round of consultations with provincial coordinators was incorporated into the draft document which again followed another consultation with a broader group of stakeholders and research retrieved from collaborations such as the Mental Health and Poverty Project funded by the DIFD programme

2013

South Africa released the National Mental Health Policy Framework and Strategic Plan (2013-2020). The driving force behind this **initiative was the recognition of the inadequate implementation of the existing Mental Health Care Act (2002)**. While these acts provided guidelines for mental health service, **provinces faced challenges in adapting them to their specific context**. The new framework and plan **prioritised implementation and offered practical guidance, steps, and measurement tools to facilitate easier integration of mental health policies into practice**. The plan highlighted the importance of recovery-oriented and disability-inclusive, public-health approaches, as well as the intersectoral nature of mental health services. Based on its human right focus for different MNS patients, the NDoH took this plan and used it to develop its framework and strategy for Disability and Rehabilitation Services in South Africa. This showcased how integrated many healthcare services are and that policies would need to feed into each other to ensure seamless healthcare service delivery.

The SA MH Policy sets out the key aims of integrating mental health care into PHC as follows:

- Expand integrated primary mental health services
- Raise public awareness and reduce stigma
- Collaborate across sectors to promote mental health
- Empower local communities, especially service users and carers

- Protect the human rights of those with mental disorders
- Address the link between poverty and mental health
- Establish a monitoring and evaluation system
- Ensure evidence-based planning and provision of services

2023

The National Mental Health Policy Framework and Strategic Plan (2023-2030) built upon the previous plan with a **focus on evidence-based mental health services**. The new framework addresses imbalances in service provision between rural and urban areas, **emphasises strengthening community-based and integrated service** in line with WHO guidelines, and provides **clearer mechanisms for monitoring implementation** with a defined list of 18 priority mental health indicators.

It is important to note that current data collection systems, particularly the District Health Information System, do not adequately cover mental health indicators, posing a challenge for routine planning and management of mental health services. Without addressing this data gap, future reforms of mental health policy may face similar challenges.

Lessons Learnt across policy updates

The 1997 guidelines lacked formal adoption protocols and were not widely disseminated resulting in various levels of provincial implementation. The 2002 Act focused on user experience and rights as well as tailoring the approach to meet the needs of individuals accessing care, improving adherence to protocols by provinces unlike the 1997 policy. In 2013, the National Mental Health Policy Framework and Strategic Plan (NMHPF) was established because of inadequate implementation of the Act as provinces faced challenges in adapting the Act to specific contexts. The new framework prioritised practical guidance and tools to facilitate policy into practice. These updates in policy shows that policy makers have been adapting and changing policy based on outcomes of previous policies and their implementation, learning and improving policies over time. The most recent National Mental Health Policy Framework and Strategic Plan (2023-2030) provided clearer mechanisms for monitoring progress over time to better learn about policy implementation and develop future policies in accordance.

When assessing the changes within mental health policy from the first 1997 policy to the current National Mental Health Policy Framework and Strategic Plan (2023-2030) the following factors were not considered in the 1997 policy, but are considered in the new policy:

- **Intersectoral collaboration** between government departments, non-government and community-based organisations for the planning of mental health services
- **Integration of mental health care** into general health services where possible
- Accessibility and **availability of mental health services** regardless of race, sex or geographical location
- Balance between mental health and other health services in terms of **allocation of human and financial resources**
- Emphasis on the **promotion of mental health and prevention of mental illness**

- Development of special programmes for **"at risk" groups**

- Development of **partnerships with private** mental health professionals and traditional healers to increase the "service net"

- Thorough and **appropriate training and ongoing supervision** to facilitate the decentralisation and integration of mental health care

- Specialist mental health personnel that provide **vertical support to integrated mental health care**, particularly the provision of special programmes

- **Partnerships with training institutions**, including the education of students, in the process of changing models of mental health care

- Involvement of communities and mental health service users and their families in the **planning and evaluation of services**

Under the new plan services include mental health promotion, prevention of mental health issues, treatment, rehabilitation, and disability inclusive development. The new plan also promotes the concepts of task-sharing and task-shifting as strategies to increase access to comprehensive mental health care services at the district level to compensate for the scarcity of specialised service providers. There is no clear strategy for ensuring the necessary skills mix is available to implement the framework for disability and rehabilitation services. To enable policy implementation, it is crucial that training programmes ensure service providers are equipped with the necessary competencies to undertake roles and functions pertinent to MNS disorders. Mechanisms for quality assurance of competences must be enforced and clarified and additional time spent on MNS patients' needs to be considered in the context of already overburdened workers.

Policy Alignment with NSP and MH Policy & Framework use case as per a stakeholder interview

The new Mental Health Framework and the new NSP align. This alignment occurs around concepts of integrating mental health into general healthcare and other areas such as HIV and TB. This is especially useful when considering the high rates of comorbidities occurring between mental health and other communicable and non-communicable diseases where the relationship goes vice versa. The NMHPF will align the integration of mental health and HIV services in a way that no individual will feel discriminated and noted that part of the reason the previous mental health policy framework was not implemented was due to a lack of resources, with HIV being better resourced than other health areas it is unlikely to be the case this time around. There is also scope for mental health policy planning to learn from the HIV/TB NSP to guide them in operationalising this integrated approach through a model that makes sense to the people living with HIV. Making this integration of policies into the NSP a reality will however require integration at the local level on how to operationalise the NSP goals and objectives with those of mental health.

COMPARING SOUTH AFRICA'S MENTAL HEALTH POLICIES TO BEST PRACTICES

Health policy development globally has been described as a complex and continuous process with opinions of various groups such as government, the public, foreign agencies, and disease specific interest groups. The WHO-AIMS framework (WHO, 2005)[206] is one of the most used tools for assessing mental health systems of a country. This framework consists of six domains covering components needed to strengthen mental health systems, one of which is Policy & Legislative Framework. The policy sub-domains assessed include:

1. Mental health policy
2. Mental health plan
3. Mental health legislation
4. Monitoring and training on human rights
5. Financing of mental health services

This framework provides an overview of which aspects to consider during policy development to ensure a well-formulated and considered policy. Additionally, the WHO Mental Health Policy Checklist (Draper et. al, 2009)[207] was designed to assess the content and process of developing mental health policy and plans. The guide contains a range of questions which needs to be evaluated.

A 2009 study (Draper et. al, 2009)[207], did an analysis of the 1997 Mental Health policy in South Africa and how its development process compared to the WHO process of policy development. It is however important to note that these guidelines were not available at the time of drafting the 1997 Mental Health Policy. Policies developed after 1997 in South Africa for mental health have followed the WHO protocols more closely except for the low prioritisation of mental health and the lack of collaboration across departments such as NDoH, DSD and other social departments (poverty, education, living conditions etc.).

Capacity development is essential at both provincial and national levels to formulate plans and programmes stemming from policy directives. Future policies should provide clear guidance on how provinces should work towards balancing the allocation of human and financial resources, the role and involvement of community structures, private and public partnerships, service providers, training provider collaborations for capacity development and quality improvements as well as the role of information systems.

Policy development and approval process

In South Africa both the process of development and the approval process are quite consultative and lengthy with timelines of provincial targets dependent on the availability of resources at the national and provincial level. The process of policy development follows an 8-step process as seen in the image below.

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[206] WHO. (2005). World Health Organisation Assessment Instrument for Mental Health System. Version 2.2. Available at: https://iris.who.int/bitstream/handle/10665/70771/WHO_MSD_MER_05.2_eng.pdf?sequence=1

First, the need for the policy would be identified, followed by the identification of the relevant departments to drive the specific policy. Once the department was identified, a working group would be summoned to compile the policy and inform provincial stakeholders of the new policy in development. This working group will include relevant mental health stakeholders for example child and adolescent mental health specialists, substance abuse specialists and relevant government officials pertaining to the policy. Relevant literature and country case studies would be used to inform the development of a draft policy document by the working group.

In addition, consultations with representatives of other departments and policy areas would be included. At this stage the draft policy would be shared more broadly for stakeholder comment after which provincial stakeholders would coordinate the policy input and consult with other provincial and district stakeholders. The policy would then be finalised, costed and submitted to the Department for approval (Draper et. al, 2009)[207].

When looking at the approval process there are a multitude of steps which need to be taken before a policy will be drafted and costed by provinces for their specific implementation. Figure 33 provides an overview of the process of policy approval once drafted.

Figure 33: Process of Policy Approval in South Africa (Draper et. al,2009)[207]
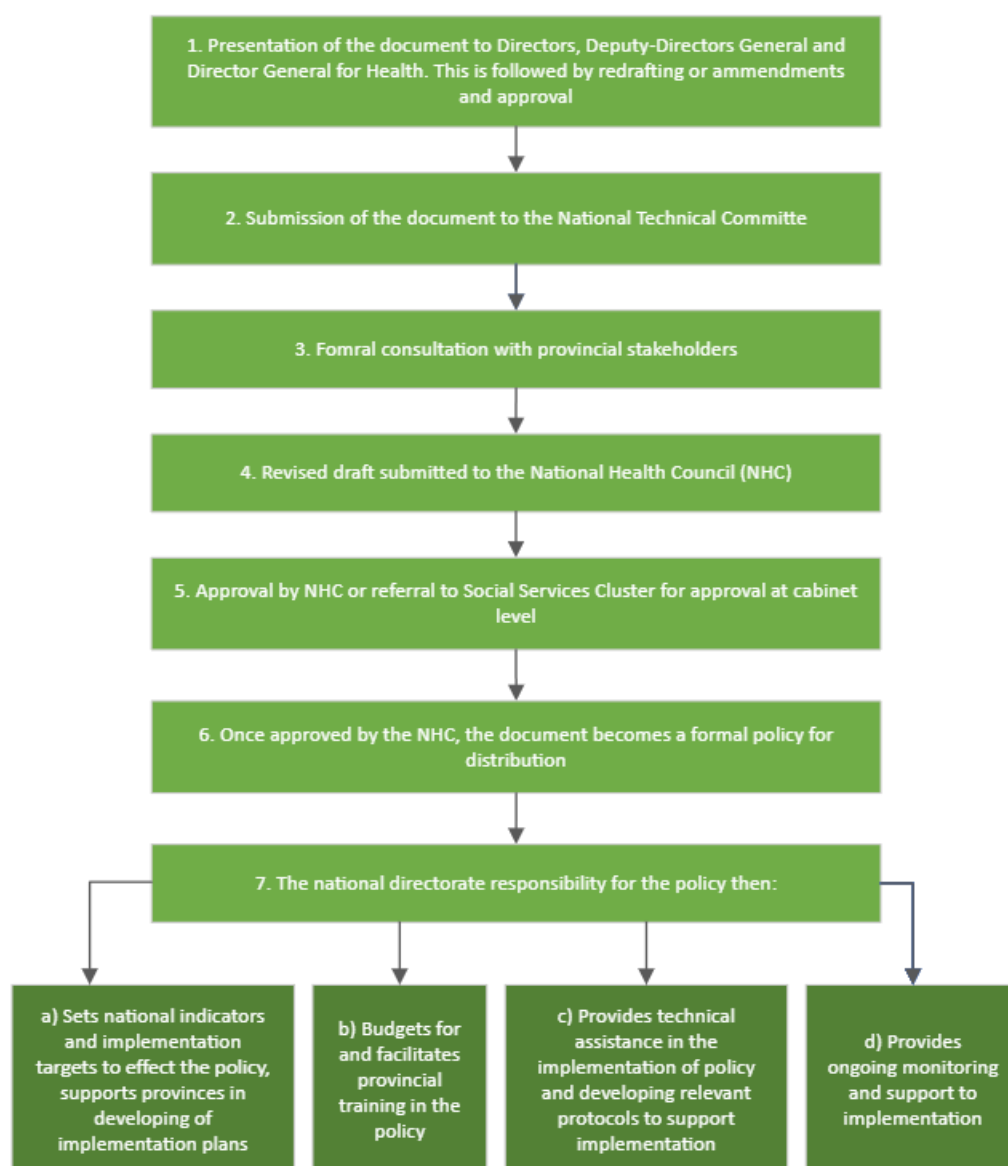
Once the policy has been submitted for approval it then gets presented to Directors, Chief Directors, Deputy-Directors Generals and the Director General for Health. This step is followed by redrafting, amendments, and approval. This then gets submitted to the National Technical Committee, followed by a formal consultation with provincial stakeholders. The revised draft is then submitted to the National Health Council (NHC) for approval or referral to the Social Services Cluster for approval at the cabinet level. Once approved by the NHC, the document is then formalised and ready for dissemination. The national directorate then has the responsibility to:

- Set national indicators and implementation targets to affect the policy and support provinces in developing implementation plans
- Budget for and facilitate provincial training in policy

- Provides technical assistance in the implementation of policy and developing relevant protocols to support implementation.
- Provide ongoing monitoring and support to implementation

These will all feed into the provincial plans which need to be drafted by the Heads of the provincial health departments. These plans should include a detailed costing and budget for approval.

While lengthy and resource intensive, South Africa's policy development process is closely aligned to the WHO defined steps for policy development of mental health policies.

When comparing South Africa's first 1997 mental health policy against WHO requirements there was appropriate consultation, negotiation, and exchange with other countries, however there was an inadequate effort placed on assessing the needs of the population, gathering evidence for effective policy, setting out the vision, values, principles and objectives, and determination of areas for action. There was no effort made to identify the roles and responsibilities of the different sectors and no pilot projects were conducted. Using the WHO guide on mental health policy formation showed clearly where South Africa's policy failed and it was evident when looking at the uptake of the policy. Barriers to insufficient implementation was described to be because of insufficient staff to drive and conduct processes coupled with a lack of clear objectives (Draper et. al, 2009)[207].

Additionally, a lack of dissemination and consequently implementation was noted partly owing to different perspectives and consensus on the state of the policies. For example, many provincial staff were unaware that the policy had been accepted and was ready for implementation. Many staff had not even received a copy of the policy hindering the chance of implementation. Given the lack of information being shared there was also a lack of clarity on whose responsibility it was to lead implementation. The provincial department of health failed to take up the responsibility of implementing the national mental health policy guidelines. The lack of adherence to procedural processes for policy implementation as well as the lack of human resources within the National Directorate may have influenced the lack of appropriate support in implementation of the policy, as well as the slow progress in the finalisation of specific policy guidelines driven by the national office (Draper et. al,2009)[207].

At the time the 1997 policy guidelines were being developed, policy development processes were themselves in the process of development in South Africa. Mental health was not prioritised as other diseases such as HIV/TB leading to a lack of resources and drive both nationally and provincially (Draper et. al,2009)[207].

The second policy developed for mental health was the Mental Health Care Act (2002). This act was developed through an extensive consultation process and has been praised for elements such as that it is human rights-based and its promotion of community-based care. Additionally, the Act encourages collaboration among stakeholders, ensuring a collective effort in implementing and evaluating mental health policies, leading to

ongoing improvements and a responsive mental health system. Since the national policy was not recognised at the time, the Free State and Northwest proceeded to develop their own provincial mental health policies using the 2002 Act as a guide. The MHCA 2002 adheres to the WHO best practice and human right principles, however a key weakness identified with the 2002 Act was the lack of a structured dissemination process (Draper et. al,2009)[207].

The National Mental Health Policy and Strategic Plan Framework (2013-2020) similarly is aligned with WHO recommendations and was based on an extensive consultation process at national and provincial levels. Both policies provide guidance on integrating mental health into PHC and community care settings as well as human right protective mechanisms. The development of the Mental Healthcare Strategic Policy and Framework for South Africa is seen to be a valuable tool to support the implementation of the 2002 Mental Health Act (Draper et. al,2009)[207].

The major differences between this policy (NMHPF 2013-2020) and the 1997 publication was the latest policy provided practical recommendations and suggestions for provincial implementation of national guidelines while the 1997 policy simply indicated the national stance on mental health. Additionally, the Department of Health noted that the new policy will build on the excellent work of the 1997 policy guidelines, addressing gaps, accounting for changes which have occurred since its drafting, and undertaking a formal process of publication and dissemination to ensure that the policy is widely known and used as official policy.

Three core components as within this policy are that mental health care should be provided by community residential facilities, day care and outpatient services. The bulk of care should be provided by primary health care (PHC) practitioners, with specialist supervision and care for MHCUs with more complex conditions requiring specialised assessment and/or intervention. Advantages of community mental health services (CMHS) over psychiatric hospital–based care lie not only in that they meet the legal and human rights of mental health care users (MHCUs) to receive care close to home, but also in their modelled cost-effectiveness in terms of improved population coverage (Draper et. al,2009)[207].

OTHER POLICIES, REGULATION & LEGISLATION INFLUENCING MENTAL HEALTH IN SOUTH AFRICA

Mental health policy is not developed in isolation. As with most policies in South Africa it is based on and consistent with several other relevant existing policy and legislation mandates. Policies which it relates to includes the following list:

1. The Constitution of the Republic of South Africa, 1996.

2. The White Paper for the Transformation of the Health System in South Africa, 1997.

3. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

4. Guidelines for the licensing of residential and day care facilities for people with mental and/ or intellectual disability

5. National core Standards for health establishments, 2011

6. Disability Rights Charter of South Africa

7. National patients' rights charter

8. Employment Equity Act 55 of 1998

9. National Health Act Guide, 2019

10. Comprehensive Primary Health Care Package for South Africa.

11. The National Health Policy Guidelines for Improved Mental Health in South Africa, 1997.

12. National Health Act, Act 63 of 2003.

13. Mental Health Act No.18 of 1973

14. Mental Health Care Act, Act 17 of 2002.

15. Correctional Services Amendment Act 7 of 2021.

16. Medicine and Related Substances Amendment Act 59 of 2002.

17. Occupational Health and Safety Act, Act 85 of 1993.

18. Pharmacy Act, Act 53 of 1974 as amended.

19. Nursing Act, Act 33 2005.

20. Health professions amendment act 29 of 2007.

21. Choice on Termination of Pregnancy Act, Act 92 of 1996.

22. Public Finance Management Act, Act 29 of 1999.

23. The Children's Act, Act 38 of 2005.

24. Prevention of and treatment for Substance Abuse Act, No. 70 of 2008.

25. National drug master plan 2019-2024.

26. Health Sector Drug Master Plan, 2019-2025

27. Promotion of Access to Information Act, Act 2 of 2002.

28. National Adolescent and Youth Health Policy, 2017.

29. Integrated School Health Policy, 2012.

30. Child and Adolescent Mental Health Policy Guidelines, 2003.

31. Child Justice Act, Act 75 of 2008.

32. Sexual Offences Act, Act 32 of 2007.

33. Older Persons Act, Act 13 of 2006; and

34. Criminal Procedure Amendment Act, Act 65 of 2008.

35. White paper on the rights of persons with disability

36. UN Convention on the Rights of Persons with Disability

37. Non-communicable diseases strategic plan

38. Special Needs Housing Policy

39. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

Influence of other policies on mental health and their interrelation

The mental health policy of South Africa relates to the [Constitution of the Republic of South Africa, No 108 of 1996](#) through its mandates which emphasises the right to health, including mental health, guiding policies to ensure accessible services. Additionally, principles of equality, dignity, children's rights, and access to courts influence mental health policies by promoting non-discrimination, respecting individuals' worth, addressing unique needs of children, and ensuring legal recourse. While not explicitly mentioning mental health, its broad provisions indirectly influence mental health policy by supporting a comprehensive approach to well-being and healthcare.

The [White Paper for the Transformation of the Health System in South Africa](#) focuses on an integrated healthcare approach, equitable access to healthcare, community-based care, prevention and promotion of health issues as well as patient-centred care. This paper guides mental health policy by advocating for an integrated healthcare approach that includes mental well-being. It emphasises equitable access to healthcare, community-based care, preventive measures, and patient-centred care, influencing mental health policies to align with these principles for a comprehensive and inclusive healthcare system.

The [Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000](#) is a significant legislative framework in South Africa which is aimed at preventing discrimination and promoting equality across various sectors including healthcare. This act promotes anti-discrimination in health services, inclusive health policies, equal treatment and access, protection of rights and a holistic approach to health. While the act may not explicitly mention terms like mental health, its overarching goal of preventing unfair discrimination implies protection for individuals facing discrimination due to mental health conditions. The act's emphasis on equality and non-discrimination supports the broader societal shift towards acknowledging and addressing mental health issues as part of a more inclusive approach to well-being.

The [Guidelines for Licensing of Residential and Day Care Facilities for People with Mental and Intellectual Disabilities](#) provide a clear framework determining the quality-of-service provisioning. Additionally, the [National Core Standards for Health Establishments, 2011](#) provides guidelines on the standard of care to be delivered by all health establishments. While not explicitly addressing mental health, the standards indirectly impact mental

health policy by promoting a holistic approach to healthcare, contributing to a more effective and comprehensive mental health landscape.

The Occupational Health and Safety Act 85 of 1993 prioritises the safety of workers, indirectly influencing mental health policies by promoting a supportive work environment. Its focus on well-being aligns with broader efforts to address stress, harassment, and work-related factors, highlighting its relevance in fostering holistic approaches to mental health in the workplace.

The Employment Equity Act 55 of 1998 primarily addresses workplace equality, indirectly supports mental health policy by fostering inclusive and non-discriminatory environment, contributing to overall employee well-being and reducing workplace stressors. The Act aligns with broader efforts to create supportive work cultures that promote mental health.

The Disability Rights Charter of South Africa underscores the importance of recognising and respecting the inherent dignity of individuals with disabilities, which implicitly includes those with mental health conditions. By aligning with the broader principles of international human rights frameworks, the charter contributes to the development of mental health policies that prioritise the well-being and rights of individuals with mental health challenges. This filters through into the provisioning of mental health services.

The White Paper on the Rights of Persons with Disability advocates for the rights and inclusion of individuals with disabilities, explicitly addressing mental health concerns within its framework. By emphasising non-discrimination and accessibility, the policy indirectly guides mental health policy, promoting inclusive mental health services and support for those with disabilities.

The UN Convention on the Rights of Persons with Disability guides South Africa towards inclusive mental health policies by emphasising equality and non-discrimination. While not explicitly mentioning mental health, its broad principles encompass disabilities, influencing a right-based approach to mental well-being in the country.

The Special Needs Housing Policy which is not yet complete addresses housing accessibility for individuals with disabilities, potentially influencing mental health policy by fostering inclusive living environments. The policy's focus on inclusive housing suggests a recognition of the interconnected nature of disabilities, indirectly contributing to mental well-being.

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 promotes inclusive mental health policies by discouraging discrimination based on mental health conditions and fostering a supportive environment. Its relevance lies in shaping a fair and equal access framework for mental health services, aiming to reduce stigma and ensure equitable treatment.

Non-communicable Diseases Strategic Plan addresses health challenges like cardiovascular diseases and cancer through a multifaceted approach. The plan's emphasis on integrated healthcare suggests potential positive impacts on mental health policy, fostering a comprehensive approach to overall well-being in the country.

The National Patients' Right Charter is a comprehensive document outlining the rights and responsibilities of patients within the healthcare system. In steering mental health policy, the charter holds relevance by implicitly supporting the rights of individuals with mental health conditions. Although the act may not explicitly mention terms like mental health, mental well-being etc. its emphasis on dignity and access to healthcare implies a commitment to addressing mental health concerns within the broader healthcare framework.

The Correctional Services Amendment Act 7 of 2021 introduces reforms to enhance offender rehabilitation, focusing on parole conditions and community corrections. While not explicitly mentioning mental health, the act's rehabilitative approach implies a recognition of the importance of mental well-being in offender reintegration, contributing to a more holistic correctional system.

The Criminal Procedure Amendment Act, 65 of 2008 is primarily concerned with criminal law procedures, indirectly influencing mental health policy by addressing the assessment of accused individuals' fitness to stand trial. While not explicitly mentioning mental health, the act's provisions aim to ensure fair treatment for individuals with mental health challenges within the criminal justice system.

The Sexual Offences Act, 32 of 2007 provides a comprehensive legal framework that not only addresses sexual offenses but also prioritises the mental well-being of survivors through accessible support and services. By incorporating provisions for counselling and therapy, the act contributes to a victim-centred approach, aligning with broader efforts in mental health policy to recognise and address the psychological impact of sexual trauma.

National Health Act Guide 2019 Influence mental health policy in South Africa by safeguarding rights, guiding human resources planning, supporting research, ensuring standards compliance, and providing a regulatory foundation, thus enhancing the overall relevance and effectiveness of mental health.

The National Health Act, 63 of 2003 provides a comprehensive regulatory framework in South Africa, emphasising the right to healthcare and establishing principles for equitable service provision. While not explicitly mentioning mental health terms, the act indirectly supports the integration of mental health into broader healthcare policies, reflecting a commitment to a holistic and inclusive approach.

Medicines and Related Substances Amendment Act 59 of 2002 regulates the registration and use of medicines, establishing standards for safety and efficacy. The act indirectly influences mental health policy by overseeing psychiatric and psychotropic medication regulations, contributing to a safe and effective environment for mental health treatments.

The Pharmacy_Act_53_of_1974 oversees the proper dispensing of psychiatric and psychotropic medication in South Africa. By regulating practices, it contributes to a responsible and ethical framework, ensuring the effectiveness and safety of mental health policies in the country.

National Drug Master Plan 2019-2024 is a comprehensive framework addressing substance abuse through coordinated efforts across sectors, integrating prevention, treatment, and law enforcement measures. Its impact on mental health policy is significant as it recognises the interconnection between substance abuse and mental health, promoting a holistic approach and aligning with global best practices.

The Health Sector Drug Master Plan, 2019-2025 serves as a comprehensive guide for pharmaceutical management, with a notable impact on steering mental health policy. This plan aims to ensure the availability, accessibility and affordability of essential medicine while promoting rational drug use. Its relevance lies in addressing the specific pharmaceutical need of individuals with mental health conditions, aligning with global best practices, and contributing to a more inclusive and holistic healthcare system.

Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 is a comprehensive legislation addressing substance abuse through community-based prevention programmes and collaborative efforts among stakeholders. Its relevance lies in steering mental health policy by recognising the interconnected nature of substance abuse and mental health, emphasising a holistic and integrated approach to tackle these issues.

Nursing Act, 33 2005 outlines specific requirements and qualification for mental health nurses. Nurses must possess a recognised nursing qualification, be registered with the South African Nursing Council and comply with continuing education requirements. Additionally, mental health nurses should undergo specialised training in psychiatric nursing. The act plays a crucial role in shaping mental health policy by establishing standards for the education and practice of mental health nurses. It ensures a competent workforce with the necessary skills to address the unique challenges of mental health care. Compliance with the act contributes to improved patient outcomes and reinforces the importance of mental health within the broader healthcare system. The act's relevance lies in promoting a standardised and quality-driven approach to mental health nursing, thereby enhancing the overall mental health care landscape in South Africa. It ensures that mental health services are provided by well-trained professionals, fostering a more effective and compassionate response to mental health issues.

Health Professions Amendment Act 29 of 2007 provides guidelines for all healthcare professionals and expands the scope to regulate mental health professions in South Africa. This ensures adherence to professional standards. This amendment strengthens mental health policy by empowering regulatory bodies to establish guidelines and standards, fostering a more structured and accountable approach to mental health care.

Choice on Termination of Pregnancy Act, 92 of 1996, plays a crucial role in shaping mental health policy in South Africa by acknowledging the psychological aspect of reproductive choices. The act ensure that women have the right to make decisions about their pregnancies, reducing potential mental health stressors associated with

unwanted pregnancies. Recognising and respecting reproductive autonomy contributes to overall mental well-being, aligning with global trends promoting women's rights and mental health awareness.

Promotion of Access to Information Act, 2 of 2002 enhances transparency and citizen engagement by granting access to information. In steering mental health policy, it empowers individuals, advocacy groups and policymakers with crucial data, fostering inclusivity and informed decision-making for the improvement of mental health services.

Public Finance Management Act, 29 of 1999 establishes financial management principles for the public sector, emphasising transparency and accountability. In relation to mental health policy, the PFMA ensures efficient allocation and responsible use of funds, contributing to the effectiveness and sustainability of mental health programmes through its stringent financial controls.

The Older Persons Act, 13 of 2006 aims to protect and promote the rights of older persons, recognising their dignity, well-being, and participation in society. In terms of relevance, the act is crucial as South Africa faces an aging population. By safeguarding the rights and well-being of older individuals, it establishes a foundation for a comprehensive approach to healthcare, including mental health considerations. As mental health is intertwined with overall well-being, the act provides a framework that acknowledges and addresses the broader aspects of health affecting older persons.

Child and Adolescent Mental Health Policy Guidelines, 2003 outlines a comprehensive framework aimed at addressing the mental health needs of children and adolescents. This policy emphasises early identification, intervention and support recognising the unique challenges this demographic faces and highlighting the importance of promoting mental well-being from an early age. In steering mental health policy, these guidelines serve as a critical foundation by providing a specific focus on children and adolescents. The policy encourages the integration of mental health services into primary healthcare, schools, and community settings, ensuring a holistic approach to addressing mental health issues at various levels. By doing so, it actively contributes to shaping mental health policies that cater specifically to the needs of young individuals in South Africa. The relevance of the policy is evident in their emphasis on prevention and early intervention, acknowledging that addressing mental health concerns in youth can have long-term positive effects. By promoting awareness, reducing stigma, and fostering an environment that supports mental well-being, the guidelines contribute to creating a society that values and prioritises the mental health of its youngest members.

The Children's Act, 38 of 2005 focusses on the rights and well-being of children. The legislation is structured to ensure the best interests of the child are prioritised in various aspects of their lives, including custody, adoption and protection from abuse. One significant aspect of the act is its emphasis on the paramountcy of the child's best interests when making decisions. By prioritising the best interests of the child, the act recognises the importance of mental well-being in a child's overall development. This emphasis aligns with the broader goals of mental health policies, emphasising early intervention, prevention and support for children facing mental

health challenges. The relevance of the act in steering mental health policy in South Africa lies in its foundational principles that promote a holistic approach to child welfare. Recognising and addressing mental health issues early in a child's life can have long-term positive effects on their overall well-being. The act sets the stage for collaboration between legal and mental health professionals, fostering an environment where the mental health needs of children are acknowledged and addressed through comprehensive policies and interventions.

Child Justice Act, 75 of 2008 prioritises the restorative justice and rehabilitation for young offenders, recognising their unique needs and vulnerabilities. In steering mental health policy, the act underscores the importance of addressing the mental well-being of juvenile offenders, contributing to a holistic approach that aims to rehabilitate rather than solely punish.

The National Department of Health is undertaking several activities to address the needs of children who have been accused of crimes, in line with the child justice act. These activities include:

- Developing different ways of providing psychologists (educational, clinical and counselling) and psychiatrists to undertake criminal capacity evaluations in court around whether a child has criminal capacity, where the child falls within the relevant age group.
- Increasing the number of available suitable facilities and resources for children referred by the criminal justice system for forensic mental observation.
- Forming part of intersectoral committees for child justice at both national to local levels to ensure seamless and integrated service delivery to children.

The Integrated School Health Policy, 2012 plays a crucial role by recognising the significance of mental well-being in the overall development of learners. The policy integrates mental health promotion, prevention, and early intervention strategies with the school setting, acknowledging that a supportive educational environment is vital for addressing the emotional and psychological needs of students. The relevance of this policy to mental health is notable as it ensures that mental health considerations are mainstreamed into the broader educational system. By fostering a mentally healthy school environment, the policy contributes to creating a foundation for positive mental health outcomes among students. Additionally, it aids in reducing the stigma associated with mental health issues by promoting awareness and understanding within the school community.

According to the Integrated School Health Policy, 2022 the NDOH is also working on strengthening guidelines and policies related to mental healthcare for children and adolescents this includes:

- Reviewing the Child and Adolescent Mental Health Policy Guidelines adopted in 2003 to ensure it aligns with the new Mental Health Policy Framework & Strategic Plan
- Renovating mental health infrastructure where required and ensure general hospitals have psychiatric units as per the NMHPF
- Staff from public facilities to conduct screening and referral for mental health as part of the school health programmes. This will require training CHWs and PHC nurses on mental health issues and the referral process

These measures have been put in place as the ten pilot sites conducting the integrated school health programme did not identify any learner with a mental illness or substance use disorder despite the inclusion of the identification of cognitive and related development impairment in the range of services provided by the programme. Indicating that improvements in identifying mental health issues amongst learners is required through training and support.

The Department of Basic Education has developed a Care and Support for Teaching and Learning Framework which aims to strengthen and harmonise prevention, care and support policies and programmes for improved education outcomes across the nine provinces and to increase awareness across these pillars. These programmes will support the implementation of integrated school mental health programmes.

The National Adolescent and Youth Health Policy, 2017 is a pivotal tool as it integrates mental health considerations into the broader framework of adolescent and youth health. By emphasising mental well-being as an integral component, the policy acknowledges the specific challenges this demographic faces, providing targeted strategies to address mental health issues such as anxiety, depression and stress among adolescents and youth. The relevance of this policy to mental health lies in its proactive approach to prevention, early intervention, and support for mental health challenges. By recognising the unique needs of this demographic, the policy aims to reduce the stigma associated with mental health issues, fostering a more supportive environment that encourages open conversations and access to mental health services for young individuals.

The Comprehensive Primary Health Care Package for South Africa while incomplete is expected to play a pivotal role in steering the direction of mental health. By recognising mental health as an integral component of overall health, the policy is likely to emphasise the importance of mental well-being and accessibility to mental health

services. This aligns with global trends in recognising and addressing mental health issues as an essential aspect of public health.

NHI as an enabler or disabler for integrated mental health services

It has been suggested that universal health care (UHC) should involve the explicit inclusion of mental health services within reimbursement and mandatory insurance schemes as a standard, not as a complementary option (Patel and Saxena, 2019)[207]. The NHI is an opportunity rather than a threat to the improvement of mental health services, but its success depends on how the system is managed.

> *The NHI is an opportunity rather than a threat to the improvement of mental health services, but its success depends on how the system is managed.*

If mental health professionals are brought on board collaboratively and adequately remunerated for their work, then NHI could be an opportunity to improve services (Patel and Saxena, 2019)[209]. The South African government is currently moving towards developing and defining the mechanisms by which the NHI fund will operate. A significant opportunity exists to generate the economic evidence to support decision-making regarding the mental health service benefits for all South Africans, as well as the complementary system reforms and capacity-building efforts that will be needed to realise successful implementation and scale-up (Patel and Saxena, 2019)[209]. Beyond raising the global profile of mental well-being, with all sectors of society recognising its importance, the Covid-19 response has brought best practices that may be leveraged to improve mental health outcomes for all South Africans under the future NHI (Patel and Saxena, 2019)[209].

At a high level the NHI bill refers to providing school-based services to promote mental health for young people and that there is a conditional grant to invest in improving mental health services in South Africa ahead of the NHI implementation. However, it is concerning that the conditional grant budget line item for mental health is not correlated to the proposed recommended costs calculated in the Mental Health Investment Case Report conducted in 2021. There is also no mention to priority setting of NHI packages of care. The bill currently indicates that the health minister will be responsible for determining the benefits package. These decisions need to be based on economic analysis to maximise value while achieving social goals to remain objective and sound with equal considerations being made for both burden and disability adjusted years (Geffen,2023)[208].

> *It is concerning that the conditional grant budget line item for mental health is not correlated to the proposed recommended costs calculated in the Mental Health Investment Case Report conducted in 2021.*

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[207] Patel V, Saxena S. Achieving universal health coverage for mental disorders. BMJ. 2019 Sep 23;366: l4516. doi: 10.1136/bmj. l4516. PMID: 31548204; PMCID: PMC6753845.

[208] Geffen, S. (2023). 'Universal health coverage and the importance of NHI legislation for mental health in South Africa', Mental Health Matters, 2023. Available at: South African Depression and Anxiety Group (sadag.org)

Additional opportunities and challenges stemming from NHI are considered in Figure 34.

Figure 34: Opportunities and Challenges from the introduction of NHI on Mental Healthcare service delivery[210]

One of the most anticipated benefits of NHI is that all healthcare will be provided for free ensuring that people will be protected from experiencing catastrophic healthcare expenditure which can push people into debt spirals and poverty. This is especially important as the cost of mental health care is often one of the barriers preventing individuals from seeking help. Additionally, the stigma attached to mental healthcare service delivery within the healthcare sector itself is that there are other illnesses and health concerns which require more attention such as TB, HIV/AIDS. However, with the introduction of NHI mental health services will be seen as equal with other health conditions in proportion to the burden of disease and evidence for cost-effective interventions. It is assumed that with the introduction of NHI there will be more frequent discussions with provinces on strategies to improve and monitor progress with respect to implementation. To ensure this unfolds strict enforcements and consequences need to be put in place. Another opportunity stemming from the NHI introduction is that all provinces will need to develop localised plans for mental health service implementation. This plan will need to align with the overall national policy but will still act as a framework and guide to ensure appropriate implementation. Provinces will also need to outline their targets, timelines, budgets and tracking indicators – ensuring accountability (Geffen,2023)[210].

With respect to the challenges, there appears to be inadequate integration of mental health into the NHI, for example the lack of plans to ensure appropriate staff to deliver services. Sufficient staff for mental healthcare service delivery has been a critical issue in South Africa for some time and needs to be addressed to ensure the goals and ambitions of NHI can be achieved. Secondly, while the NHI concept of equitable access for all is appealing there is very limited information on how this will be achieved and upheld across different populations. There is also a lack of clarity around accreditation standards and contractual conditions which will be put in place for service providers to ensure they deliver good quality services at scale. This is a big concern as currently service quality in the South African healthcare system is not adequate and the introduction of NHI will require much more effort to ensure service quality is maintained. Finally, there is a lack of mental health experts being included

in the consultations of the NHI and on the advisory structure. These is also no robust accountability framework within the NHI with indicators included in existing information systems. This will make it challenging to ensure that NHI and its benefit packages are well suited to the needs of MHCUs. This concern and many others need to be outlined in the NHI for it to affect the change it seeks to (Geffen,2023)[210]. Further research using information from the NHI unit at NDoH could be obtained to provide a better view of what support is required to ensure MHCUs receive appropriate care with the introduction of the NHI[13].

HAVE POLICIES BEEN IMPLEMENTED & ITS IMPACT

Mental health policies in South Africa are notoriously known for lacking implementation due to a variety of reasons such as financial and human resource limitations to undertake the development of key bodies and programmes to ensure service delivery meets expectations outlined in national policies. While there has been progress in policy development and iterative changes from one policy to the next it is important to understand how policy has filtered into implementation. Across the different policies developed, guidelines have been used by some provincial mental health programme managers as well as at a national level to initiate the development of norms and standards for mental health services within South Africa. When delving into why policy doesn't get implemented provinces have cited reasons such as: (i) limited financial and human resources to drive implementation, (ii) conflicting with norms and standards already in facilities and the need to change staff perceptions on

"We need to see structured action plans in the provinces with budgets allocated so that we can hold the government departments accountable," Dr Patel.

how services should be delivered, (iii) stigma within communities and healthcare workers and (iv) lack of coordination across different departments and organisations to ensure integrated community-based service delivery (Molelekwa, 2023)[209] .

A situational analysis of public mental health services and policies in South Africa and its nine provinces undertaken in 2005 (Lund et. al,2016)[210] showed weak policy implementation at provincial level, marked inequality between provinces in terms of available resources for mental health care, lack of routine data collection for monitoring, and reliance on mental hospitals rather than more decentralised services.

The table below provides an outline of other NMHPF recommendations and their progress across the provinces following the investigative hearing:

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[209] Molelekwa, T. (2023). 'New Mental Health Policy Welcomed, but Experts Concerned Over Implementation', Spotlight news, 26 April. Available at:
https://www.spotlightnsp.co.za/2023/04/26/new-mental-health-policy-welcomed-but-experts-concerned-over-implementation/
[210] Lund C, Kleintjes S, Kakuma R, Flisher AJ. Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. Soc Psychiatry Psychiatr Epidemiol. 2010 Mar;45(3):393–404. [Internet]. [cited 24 March 2016]. URL: http://www.ncbi.nlm.nih.gov/pubmed/19506789

Table 13: Provinces progress in meeting NMHPF objectives in 2017 (SAHRC)[120]

PROVINCES	PROVINCIAL MH PLAN	PROVINCIAL MH DIRECTORATE ESTABLISHED	DSMHT IN ALL DISTRICTS	MHRB	PLAN TO REVITALISE FORENSIC & NON-FORENSIC MH INFRASTRUCTURE
Eastern Cape	Yes, but not costed	No	No	Yes, but poor compliance	No
Free State	No	Yes	One in one district	Yes, currently two	No
Gauteng	Yes	Yes	No	Yes	No
KwaZulu-Natal	No	Yes	No	Yes	No
Limpopo	No	No	No	Yes, but not fully functional	No
Mpumalanga	No	No	One in one district	Yes, one	No
Northern Cape	No	No	No	No	No
Northwest	No	No	No	Yes, one	No
Western Cape	No	No	No	Yes, one	No

In 2017 only two provinces, Gauteng and Eastern Cape established a provincial strategic plan to implement the NMHPF (2013-2020) with Gauteng being the only province to have this plan costed (SAHRC,2017)[120]. The provincial mental health directorate is a key driver of policy development and implementation of the provincial strategy. In 2017, only three of the nine provinces (Gauteng, Free State, Western Cape, and KwaZulu-Natal) had established provincial mental health directorates with the other provinces still needing to institute this role (SAHRC,2017)[120]. It is important to note however that as stated earlier in Theme 2 there has been change regarding these statuses with many more provinces now having mental health strategic plans however there are still some provinces lagging.

By 2023, six out of the nine provinces had atleast one District Specialist Mental Health Team in each district, showing that progress has been made. The table below provides an outline of all the districts across each province with an established DSMHT[211].

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[211] National Department of Health, 2023. 'District Specialist Mental Health Teams in Place: November 2023'

Table 14: District Specialist Mental Health Teams in November 2023[213]

PROVINCE	DISTRICTS
Eastern Cape	Amathole; OR Tambo; Buffalo City Metro
Free State	Thambomofutsanyana
Gauteng	Tshwane; Ekurhuleni; Johannesburg Metro; Sedibeng; West Rand
KwaZulu-Natal	None
Limpopo	Capricorn; Mopani; Sekhukhune; Vheme
Mpumalanga	None
Northern Cape	Frances Baard
Northwest	Dr K.K Kaunda; Ngala Modiri Molema
Western Cape	None

KwaZulu-Natal, Mpumalanga, and the Western Cape are the only provinces without any DSMH teams. The Western Cape and KwaZulu-Natal are generally provinces which are well resourced to be able to implement such teams, however the Western Cape noted in 2017 that it did not agree with recommendations set forth in the National Strategy and Policy Framework and preferred to focus on an integrated approach[122] which could explain the lack of implementation.

With respect to plans to revitalise forensic and non-forensic mental health infrastructure none of the provinces had plans or information on this when the investigative hearing was conducted (SAHRC,2017)[120].

Strategies for effective mental health policy implementation (SAHRC,2017)[120]

The report of the national investigative hearing into the status of mental health in South Africa, conducted by the Human Rights Council noted that government emphasises the need for government oversight, policy making and monitoring to assist provinces with the implementation of the new policy. Specifically, it suggests:

- **Providing resources specifically allocated for provincial partners to develop and implement province specific mental health plans which complement the NDOH Standard Treatment Guidelines** including minimum resource allocation for mental health services as part of the health care budget. These guidelines should include pathway to care descriptions, mechanisms for budgets to be ring-fenced and should ensure allocated budgets reach both urban and rural populations across all mental health establishments and facilities.

- **Guidelines should be developed and shared with provinces to include in their mental healthcare plans** on the inclusion of costing and budgeting to match implementation plans. These guides should take account of the parity principle outlined in the NMHPF.

- **Finalise national monitoring plans to assess each province and districts progress towards the NMHPF** annually. These **plans need to include costed and dedicated budgets, indicators** to determine the extent of improvement of community-based mental healthcare service delivery, consider the

proportion of MH budget spent on community services, the growth of the budget in terms of human resources for health and community health workers at the primary care level as well as their relevant training. Indicators should also map expanded provincial access to urban and rural services for both adults and children.

- Develop and implement a **strategy to ensure no medication stockouts**.
- **Support provincial departments to implement the recommendations in the investigative report**. Including, but not limited to, assistance and support aimed at establishing a provincial mental health directorate and developing provincial strategic plans for mental health (SAHRC,2017)[120].

In addition to the solutions outlined in the national investigative hearing report, enablers for policy implementation also include[120]:

- **Disseminate the policy effectively** to health district offices and partner agencies, targeting key individuals to ensure understanding and buy-in.
- Generate political support and secure funding to **ensure sufficient resources for implementation**.
- Establish a **supportive organisation or structure**, such as a provincial mental health directorate, to oversee and drive implementation efforts.
- Set up **pilot projects** in demonstration areas to gather insights and lessons that can inform nationwide implementation strategies.
- **Empower mental healthcare providers** through appropriate incentives, autonomy and accountability measures to deliver quality services.
- Promote **intersectoral collaboration** to expand access to mental health services and resources.
- Facilitate **interactions among stakeholders** to ensure mental health interventions meet the needs of the population.

In conclusion, prioritising resource allocation, finalising monitoring plans, and implementing crucial enablers such as effective policy dissemination, securing funding, conducting pilot projects, and empowering providers are essential steps for successfully addressing mental health challenges and ensuring effective policy implementation.

THEME 4 UNDERSTANDING THE AVAILABILITY & QUALITY OF DATA OF HEALTH SERVICES COMPARED TO NATIONAL PLANS & BEST PRACTICES
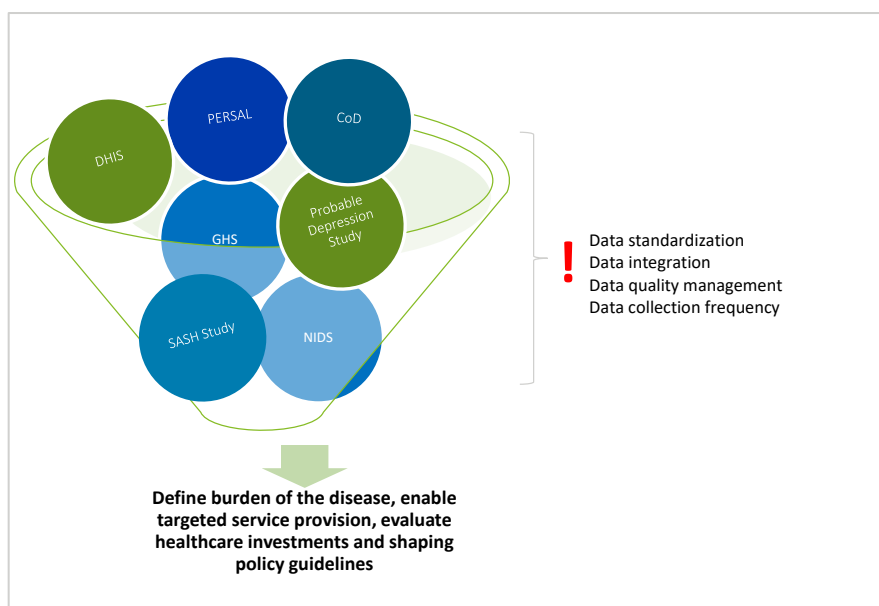
OBJECTIVES FOR THEME 4:

Conduct a comprehensive analysis of mental health services data, focussing on the District Health Information System (DHIS) in South Africa using desktop research and primary data collection through stakeholder interviews to understand what measures are available and how this data is collected and managed to track progress to goals outlined in the NDP.

The information presented in this theme will comprise a literature review of available information on mental health data in South Africa, coupled with information from relevant stakeholder interviews.

Establishing a system to track and monitor health programme performance is crucial for effective healthcare. Data serves as the foundation of any health care programme.

Figure 35: Visual representation of data sources on non-communicable diseases

Without high-quality data, countries cannot accurately comprehend the burden of disease, plan services, or evaluate healthcare investments. In the mental health space, low- and middle-income countries like South Africa have limited data due to their focus on diseases like HIV/AIDS and TB. However, there has been a growing emphasis on studies, research, and data development in mental health. South Africa currently relies on data sources such as the South Africa Demographic and Health Surveys (SADHS), South African National Health and Nutrition Examinsation Survey (SANHANES), General Health Survey (GHS), National Income Dynamic Survey (NiDs) as well as routine surveillance systems like DHIS (containing the national indicator data set) and Cause of disease registration data (CoD). Assessing the availability and quality of health service data in relation to national plans and best practice standards is crucial for scientific reporting and improving healthcare outcomes.

There are four main surveys that collect health-related data in South Africa, namely the SADHS, SANHANES, GHS, and NiDS. These surveys focus on monitoring non-communicable diseases (NCDs) and their risk factors. The SADHS and SANHANES surveys have only been conducted a few times, while the GHS is conducted annually by

Statistics South Africa. The NiDS survey collects health-related data biennially and focuses on poverty transition among South Africans.

The SADHS is the oldest of the four surveys but has only been conducted twice (in 1998 and 2003), while SANHANES, which mainly focuses on NCDs and their risk factors, has been conducted once so far (in 2011). The SANHANES report was released about a year after data collection (Department of Health,2011)[212]. The GHS, produced by Statistics South Africa (Stats SA), is more regular when compared to the earlier surveys, having been conducted annually since 2002. The last two surveys (2013 and 2014) ran from January to December, whereas previous surveys took about 2 months between July and September. Reports, including a health section showing numbers of those self-reporting diagnosis of specific NCDs, are usually released between 6 and 12 months later. NiDS, a biennial survey, has been carried out since 2008 by the Southern Africa Labour and Development Research Unit at the University of Cape Town. As part of its focus on tracking poverty transition among South Africans, NiDS collects health-related data that can be useful for monitoring NCDs and their risk factors. This panel survey has completed and availed to the public four waves of data so far, with the fifth having been implemented in 2016. Data on risk factors associated with NCDs have either been self-reported or based on measurements of relevant biomarkers (Department of Health,2011)[214].

The Department of Health in South Africa has a district health information system (DHIS), which tracks patients attending all health establishments. DHIS data is collected at the point of care and recorded at the health facility level. Data elements related to NCDs collected by DHIS include diabetes, hypertension, mental health, dental health, cataract surgery, and cervical cancer screening. However, the DHIS data is not population-based and is limited to those accessing care in the public sector. Information recorded for mental health at the PHC level includes total PHC visits, first for mental illness and follow-up visit for mental illness. At the secondary facility level, mental health visits are split by those aged 18 years and older and those younger than 18 years and specific information is recorded on referrals. Mental health data include both outpatient and inpatient clients. The number of patients admitted involuntarily to psychiatric hospitals is also reported. Referral information includes information on referrals in and out of a facility and who the referral was done by for example, the individual or the hospital (Department of Health,2011)[214].

There have been national studies estimating the rates of prevalence and incidence for mental health issues in South Africa, such as the SASH study conducted in2003 to 2004. Another recent study was the Probable depression and anxiety study conducted by Wits University in 2022. There are other studies such as the Global Burden of Disease estimates which is conducted globally; however, this study is known to be riddled with data quality concerns.

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[212] Department of Health, (2011). *'District Health Management Information System Policy'*. Available at: https://knowledgehub.health.gov.za/elibrary/district-health-management-information-system-dhmis-policy

The table below provides more details on the data sets mentioned above as well as other specific mental health studies which have been conducted over time. However, these studies have limitations, and more research is needed to address the mental health issues in South Africa.

Table 15: Data sets on non-communicable diseases and mental health

DATA SOURCE	FREQUENCY OF DATA COLLECTION	LAST REPORT	METHOD OF DATA COLLECTION	MENTAL HEALTH VARIABLES COLLECTED	QUALITY OF DATA COLLECTION
District Health Information System (DHIS)[214]	Routinely collected information	Not publicly available	Data are collected by means of a paper-based and electronic system of registers, tally sheets, and monthly data collation forms. Routine data collection occurs from primary to tertiary care nationally across all South African provinces. Data is collected by health care workers and the overall responsibility at the lowest level lies with the district health manager with subsequent checks up the value chain.	Records for mental health is aggregated into age groups below and above 18 years. Child and adolescent attempted suicide rate Mental health case load Mental health involuntary admission rate Mental health separation rate Mental health separations 18 years and older Mental health separation under 18 years PHC mental disorder treatment rate new DHIS data is not population based and includes primarily those accessing care in the public sector.	While there are many steps of quality assurance to a final data set, the quality of data within the DHIS system has been described as lacking, due to insufficient skilled staff to undertake the job of capturing and collating data.
NDOH PERSAL	Routinely collected information	Not publicly available	This online database contains information on all staff registered as health care workers. This database is managed by the Department of Health.	Useful for understanding staff resources across mental health service delivery	NDOH PERSAL is considered inaccurate and out-of-date by various stakeholders interviewed. While it captures registered practitioners it does not

DATA SOURCE	FREQUENCY OF DATA COLLECTION	LAST REPORT	METHOD OF DATA COLLECTION	MENTAL HEALTH VARIABLES COLLECTED	QUALITY OF DATA COLLECTION
					account for whether these practitioners are practicing or even still based in South Africa.
Cause-of-death (CoD) registration	Routinely collected information	Not publicly available	Death certificates registered on the national system.	May contain mental health data as related to death, but often not well described for identification.	Described as poor as many forensic audits record the incorrect cause of death.
Health Systems Trust: District Health Barometer[213]	Annually	2022/2023	Data are drawn from the District Health Information Software (WebDHIS), the Ideal Clinic Realisation and Maintenance system, Statistics South Africa (Stats SA) surveys, the National Treasury Basic Accounting System (BAS), the Personnel Administration System (PERSAL), the Three Integrated Electronic Registers (TIER.Net) for tuberculosis (TB and antiretroviral therapy (ART) data, the Electronic Drug-resistant Tuberculosis Register (EDRWeb), the National Income Dynamics Study (NiDS) and other National Department of Health information systems. Compilation of the DHB is guided by a technical working group made up of eight Public Health specialists and Health Systems Trust (HST).	Hospital level indicators of expenditure per patient per day equivalent for all categories of hospitals; and indicators of expenditure per PHC headcount for all health districts. The DHB provides data for all 52 health districts. Mental disorders treatment rate (DHIS) over the last 6 years (FY2018 - FY2023) has been included for each district.	Designated quality coordinators who perform various checks before reports are published.
General Household Survey (GHS)[214]	Annually	2022	Data is collected by enumerators on a representative sample of the South African	Contains information on NCDs, but not mental health.	Designated quality coordinators who perform various checks

[213] HST: District Health Barometer, (n.d.). Available at: Health Systems Trust (hst.org.za)
[214] DataFirst: General Household Survey Data, (n.d.). Available at: South Africa - General Household Survey 2021 (uct.ac.za)

DATA SOURCE	FREQUENCY OF DATA COLLECTION	LAST REPORT	METHOD OF DATA COLLECTION	MENTAL HEALTH VARIABLES COLLECTED	QUALITY OF DATA COLLECTION
			population using Computer Assisted Personal Interviews (CAPI).		before reports are published.
National Income Dynamics Study (NiDS)[215]	Biennial	2022	Panel, longitudinal data set taken every 2-3 years through surveys conducted over a nationally representative sample.	Contains information on mental health; but vague only related to depression & self-diagnosis.	Designated quality coordinators who perform various checks before reports are published.
The South African Stress and Health (SASH) study[23]	Once-off	2003-2004	An extensive mental health specific survey questionnaire was conducted with a national representative sample. Diagnostic assessment of lifetime and 12-month DSM-IV disorders— Diagnoses of DSM-IV (Diagnostic and Statistical Manual, 4th edition) disorders were made using Version 3.0 of the World Health Organization Composite International Diagnostic Interview (CIDI).	Specific data on lifetime prevalence & associated risk factors. The following disorders were covered: anxiety disorders (panic disorder, agoraphobia without panic, social phobia, generalised anxiety disorder and posttraumatic stress disorder); mood disorders (major depressive episode); impulse control disorders (intermittent explosive disorder); and substance use disorders (alcohol abuse, alcohol dependence, substance abuse, substance dependence). Lifetime prevalence, age of onset and 12-month prevalence were assessed separately for each disorder. Bipolar disorder, oppositional-defiant disorder, conduct	Peer reviewed study.

[215] DataFirst: National Income Dynamics Study, (n.d.). Available at: Data Catalog (uct.ac.za)

DATA SOURCE	FREQUENCY OF DATA COLLECTION	LAST REPORT	METHOD OF DATA COLLECTION	MENTAL HEALTH VARIABLES COLLECTED	QUALITY OF DATA COLLECTION
				disorder, attention deficit/hyperactivity disorder, obsessive-compulsive disorder, specific phobia and separation anxiety disorder were not assessed in the SASH study	
Probable depression study[6]	Once-off	2022	Cross-sectional study surveyed a nationally representative sample of adults (>18 years old). The sample was selected using stratification across 6 points to ensure a representative sample. Interviews were done face-to-face using CAPI. To assess probable depression, the Patient Health Questionnaire (PHQ-9) scale was used. To assess probable anxiety, the Generalized Anxiety Disorder (GAD-7) scale was used. Adverse childhood experiences (ACEs) were measured through a 12-item ACE questionnaire.	Data on probable depression & anxiety and its associated risk factors.	Peer reviewed study.

From the information available, the DHIS data source despite having its own quality concerns is the most accurate data to use to understand the current prevalence and incidence trends of mental health in South Africa. The rest of this section will hone into what this data looks like and how it could be used for evidence-based decision-making.

INFORMATION COLLECTRD BY DHIS

The DHIS (District Health Information System) is a paper-based and electronic information system that uses a combination of forms, procedures, and analytical tools (Department of Health,2011)[214]. It converts routine anonymous data into useful management information that can be used by local programme and facility managers (Department of Health,2011)[214]. The DHIS collects information related to who, what, when, where,

why, and how about the health status of people. The public sector is however moving into real-time electronic information capturing (Department of Health,2011)[214].

Regarding "who gets sick," the DHIS collects this information from client cards, registers, and tally sheets. These documents provide details on the individual and their complaints, as well as the treatment prescribed. Certain programmes like the Expanded Programme on Immunisation, antenatal care, family planning, and TB programmes use a register where each patient is recorded and followed throughout their patient journey (Department of Health,2011)[214]. For mental health care, patients are only recorded as coming in to see a nurse for the first time. Once diagnosed, they will be reported as a mental health patient seeing a relevant staff member such as an occupational therapist or psychologist (Department of Health,2011)[214].

The DHIS also focuses on tracking which diseases are occurring and covers all priority conditions such as communicable diseases and chronic diseases affecting the elderly. Other minor alignments are only recorded on a facility basis (Department of Health,2011)[214]. However, the DHIS also looks at preventative and promotive health activities, as well as rehabilitation, developmental screening, and early identification of important conditions like hypertension or asthma. The data collected can be tailored to meet the needs of the individual facility (Department of Health,2011)[214]. However, there are a set of essential data points which must be collected by all facilities delivering PHC (Primary Health Care) services. Different data can be collected across different points in the health provision pyramid, as seen in Figure 36 below:

Figure 36: Flow of information within the DHIS[214]
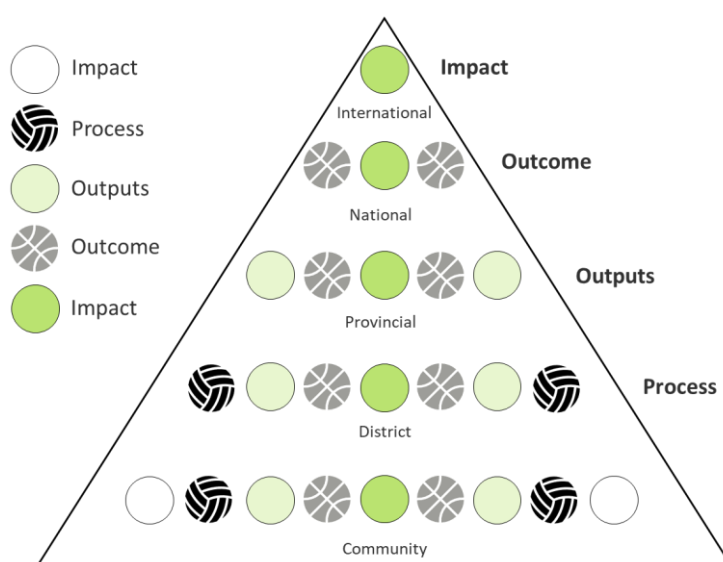
The DHIS system collects different types of data, including activity data about patients seen and programmes run, routine services, and epidemiological surveillance. It also collects semi-permanent data about the population served, the facility itself, and the staff that run it (Department of Health,2011)[214].

At the lowest level, community health care providers are required to collect detailed and comprehensive information. As you move up to provincial and national level facilities, less data input is required, with a focus on data consolidation of district and sub-district information with other provincial facilities. Data undergoes processing, filtering, and streamlining as it moves from districts to provincial and then national levels (Department of Health,2011)[214].

Since the DHIS collects data at the facility level, it can easily identify and describe population health outcomes by geography, which is relevant for planning of health services and outbreak diseases (Department of Health,2011)[214]. The data collected by the DHIS is aggregated monthly, allowing for trend analysis across population health outcomes (Department of Health,2011)[214]. The DHIS also acknowledges the links between various socioeconomic outcomes and health and has environmental health officers trained in understanding the links between health, outbreaks, and the environmental situation underlying these to ensure that when data is evaluated, this lens is also applied in planning for health service provisioning (Department of Health,2011)[214].

The DHIS system enables the healthcare sector to identify key factors such as age and location to plan, implement, and evaluate interventions to improve health outcomes. It also facilitates the identification of struggling and best practice facilities, promoting mutual learning opportunities.

Besides information on diseases, the DHIS also tracks what services exist by providing information on the full spectrum of PHC services offered at clinic, community, and hospital levels (Department of Health,2011)[214]. In addition to this, there is a wealth of information on the health infrastructure such as the state of the facility building, staff numbers, equipment available, frequency of services provided, as well as measures of quality of care (Department of Health,2011)[214]. It is, however, the responsibility of each facility to make sure this information is up to date to assure the facility is properly resourced.

There are also specific kinds of data collected for special programmes with distinct indicators which need to be tracked. For example, under the EPI, the indicator tracked is the percentage of children under 1 year fully immunised. Routine service data records activities that do not form part of the special programmes or disease surveillance, which should be collected on tally sheets (Department of Health,2011)[214]. In terms of epidemiological surveillance, data is collected about notifiable diseases, environmental conditions, and risk factors which need immediate action to prevent potential outbreaks or epidemics (Department of Health,2011)[214]. While surveillance should be done by all facilities, there are sentinel sites which make special efforts to collect this information (Department of Health,2011)[214]. For example, each province has several HIV sentinel sites where blood testing is more frequent, antenatal surveys are done each October, and research is carried out that will inform planners and policymakers of trends in the HIV epidemic. Other routine data collected by the DHIS is presented in the table below.

Table 16: Types of data collected by DHIS[214]

DATA TYPE	INFORMATION COLLECTED
Administrative data	Number of nurses working days, and out of stock indicator along with headcounts and numbers of patients referred are collected and sent upwards monthly by the DHIS. Other data may be recorded locally, but only if it is used.
Organisational unit infrastructure & equipment data	This data concerns the state of the facility, the staff working there, the amount and condition of the equipment and the general infrastructure. This data was originally collected on Regional Health Management Information System (ReHMIS), but this data is now out of date and various methods are being used to update and simplify it. The Office of Health Standards and Compliance conducts audits and checks to ensure quality and safety in healthcare in South Africa.
Human resources data	Data on current staff members and gaps in terms of staff needed.
Logistical data	Data about logistics and backup support in the form of transport, drugs, laboratory and X-ray services needs to be collected carefully by facilities
Financial data	Most financial management is currently done at district level or higher, but with increasing decentralisation, each facility should eventually become a "cost centre" within the district, with the facility manager controlling expenditure according to a budget.
Population data	This includes census data, data for estimating the facility catchment population as well as information on births and deaths.

The DHIS is a system that focuses on primary healthcare services and district hospitals while aiming to provide a comprehensive view of all health-related activities within the district. In 2017, the web based DHIS2 system was implemented across most facilities, except for facilities with poor network abilities limiting online access. These facilities are however being supported through routers to assist the move to the web based DHIS. The computerisation is designed to connect with other computerised systems, such as vital registration (births and deaths), laboratories, transport, pharmacy (Medical Supplies Administration System (MEDSAS)), financial (FMS, BAS), and personnel (PERSAL) systems (Department of Health,2011)[214] but currently this integration does not exist.

When comparing the mental health data collected by DHIS and the Ideal Clinic; the similarities are both reporting mental health case load (%) , however ideal clinic data also includes information on diagnosis, treatment and adherence which allows observation of the entire patient journey, compared to DHIS which essentially only tracks new mental health patients (the first time they present at a clinic) who receive treatment for mental healthcare. As the DHIS data is collected across multiple facilities and not just clinics, it also includes useful information such as child and adolescent attempted suicide rates, involuntary admission rates, separation rates for individuals below and above 18 years as explored across Theme 1 and 2 of the report. The ideal clinic data also includes information on mental health human resources and support groups for mental health, which DHIS does not.

HOW THE DHIS INFORMATION IS MANAGED

Data collection

Data is collected from various health programmes, such as school health, family planning, AIDS, TB, Nutrition, etc. Additionally, data from communities, such as census, birth and deaths, surveys and research, local government, and health committees is also collected. This information is then sent to the direct health management team (Department of Health,2011)[214].

Data from health service delivery directly flows into the district information centre and database (Department of Health,2011)[214]. The health service delivery data includes non-government (including NGOs, private sector, traditional healers) and government-provided health services. Government-provided services include data from health centres, clinics, hospitals (in and outpatients), mental health, maternity health, dental health, environmental health, referrals, and other health services (Department of Health,2011)[214]. The image below provides an overview of these data flows.
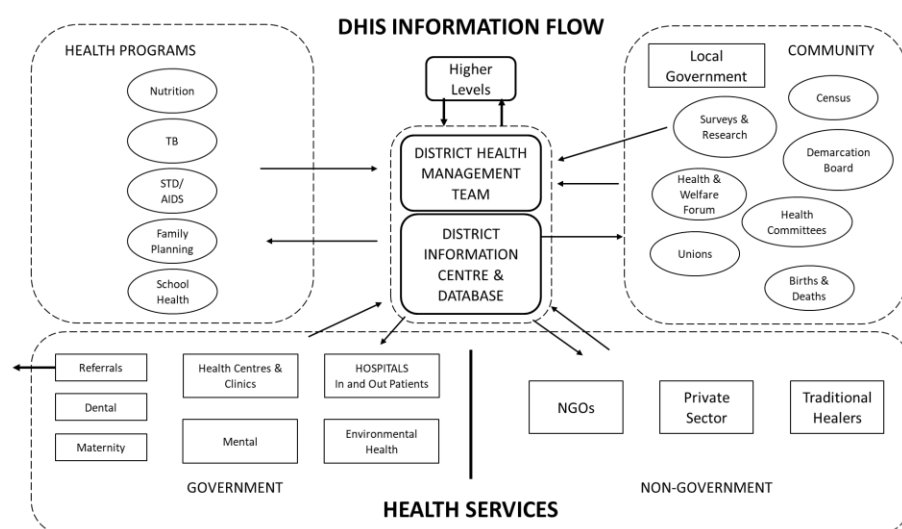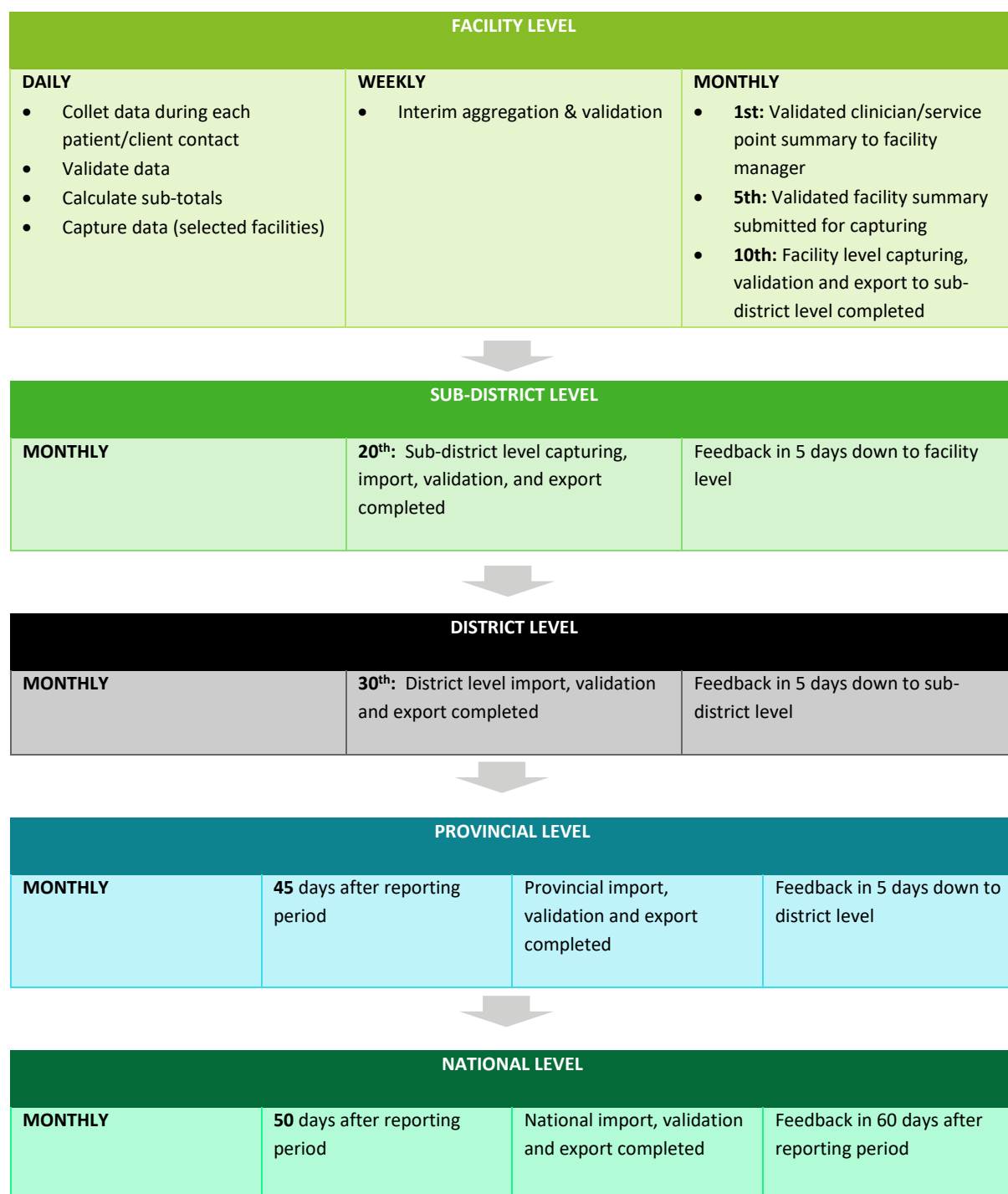
Figure 37: DHIS information and data flows[214]

Figure 37 outlines the monthly routine for data reporting within the DHIS. Facilities are required to report data daily, validate, and record it by the end of each day. Weekly, interim aggregation and validation of this data must be conducted. On the first day of the new month, validated service point summaries are provided to facility managers, with validated summaries submitted for capturing by the 5th and exported to the sub-district level by the 10th (Department of Health,2011)[214].

At the sub-district level, all facility data must be imported, validated, and exported by the 20th of the month, with feedback provided to facilities within 5 days. This information is then sent to the district level, where data from the sub-district is imported, validated, and exported by the 30th, with feedback provided within 5 days (Department of Health,2011)[214].

Provincially, completed district information must be imported, validated, and exported 45 days after the reporting period, with feedback provided to districts within 5 days. At the national level, all information is imported, validated, and saved 50 days after the reporting period with feedback provided to provinces within 60 days (Department of Health,2011)[214]. Based on information from stakeholder interviews, currently, 95% of all facilities nationally meet quality assurance monthly deadlines and there is a 98% rate of completeness across all facilities.

Figure 38: Monthly routine data reporting flow diagram[214]

FACILITY LEVEL		
DAILY • Collet data during each patient/client contact • Validate data • Calculate sub-totals • Capture data (selected facilities)	**WEEKLY** • Interim aggregation & validation	**MONTHLY** • **1st:** Validated clinician/service point summary to facility manager • **5th:** Validated facility summary submitted for capturing • **10th:** Facility level capturing, validation and export to sub-district level completed

SUB-DISTRICT LEVEL		
MONTHLY	**20th:** Sub-district level capturing, import, validation, and export completed	Feedback in 5 days down to facility level

DISTRICT LEVEL		
MONTHLY	**30th:** District level import, validation and export completed	Feedback in 5 days down to sub-district level

PROVINCIAL LEVEL			
MONTHLY	**45** days after reporting period	Provincial import, validation and export completed	Feedback in 5 days down to district level

NATIONAL LEVEL			
MONTHLY	**50** days after reporting period	National import, validation and export completed	Feedback in 60 days after reporting period

Data collation at all levels is computerised using the DHIS software, enabling accurate calculation and comparison between facilities (Department of Health,2011)[214]. Monthly reports are filled at the clinic level and sent to supervisors or district information offices within five days of the end of the month (Department of Health,2011)[214].

Data quality

Data quality in the DHIS system is ensured through user-friendly data collection tools that can be customised to exclude irrelevant sections. Glossaries clarify terms, while comment spaces allow for clarification. Facility managers and supervisors verify data entry, and standardised reporting procedures are enforced, with computerised quality checks and monthly feedback provided (Department of Health,2011)[214].

Staff responsibilities

Different staff members have distinct roles and responsibilities in the collection and collation of DHIS data. The table below provides an overview of the staff member and their respective responsibilities.

Table 17: Staff responsibilities for DHIS data collection & collation[214]

STAFF MEMBER	DAILY	WEEKLY	MONTHLY
Receptionist/Patient Registration Staff Responsibilities	• Draw patient clinical records from the filing facility or issue new patient clinical record (double check for existing record to avoid duplication). • Record the visit as a headcount each time a patient presents to the facility for any service in the Reception Headcount Tick sheet before the patient clinical record is handed to health care provider • Each patient should be counted once a day, regardless of the number of services provided at the facility • A new reception headcount tick register should be started each day • No patients should leave the facility without their clinical record. In the case of referrals, the referral facility should have the original clinical record • Adding and double-checking sub-totals at the bottom of	• Completing and double checking the weekly reception headcount summary sheet • Entering daily totals of the reception headcount tick sheet into the weekly reception headcount summary sheet	• Entering the weekly totals of the weekly Reception Headcount summary Sheet into the monthly Reception Headcount summary sheet • Add and double check the monthly Reception Headcount summary sheet and submit to the facility manager on the 1st day of each month • Filing and storing the headcount tick register, weekly and monthly summary sheets, copy of data input forms completed by facility manager in a locked facility for monitoring and auditing purposes

STAFF MEMBER	DAILY	WEEKLY	MONTHLY
	each Reception Headcount Tick Register • Storing the Tick Register in a locked facility		
Health care providers (nurses, doctors and other health professionals)	• Record individual patient data in facility clinical records • Record all required data in line with NIDS definitions in the tick register during or directly after each patient contact • Indicate patient number (for patient follow-up and audit purposes) • Double check all recorded information and correct health care interventions recorded for patients who received them • If the facility does not have data capturers, the health care provider will need to transfer information from the tick register to programme specific longitudinal registers such as TB registers at the end of each day • Calculate, capture and sign off daily sub-totals • Submit for daily DHIS capturing in relevant facilities	• Complete and sign weekly tick register summary form • File and store weekly tick register summary in a locked facility	• Add the totals for each data element in the standard registers on the first day of each month and get a monthly total for the previous month • Copy totals to the tick register summary form to be submitted to facility manager on the 1st day of each month

STAFF MEMBER	DAILY	WEEKLY	MONTHLY
	• File and store tick register in locked facility should there be no data capturer to do so		
Data Capturers	• Collect tick registers completed by health care providers per service point and capture into DHIS • Conduct rapid data quality assessment on tick registers before capturing • Run absolute validation per service providers and verify data with health care provider • Follow up on discrepancies with health care providers	• Complete and sign weekly tick registers summary form • Store weekly tick register summary form in a locked facility	• Complete and sign the monthly tick register collation form and submit to the facility manager on the 1st day of each month • File daily, weekly, monthly tick register summary forms together with a copy of the data input form completed by facility manager • Capturing data into DHIS

From a high-level and governance perspective, the key responsibility of the health information officer is to oversee the development and implementation of effective health information systems and processes, including data collection, validation, and analysis. They ensure the accuracy and reliability of health data for informed decision-making and policy development. The facility manager is tasked with ensuring the efficient operation of the healthcare facility, which includes managing resources, overseeing data management practices, and utilising health information for improving patient care and facility performance (Department of Health,2011)[214].

DHIS development

In October 2012, the DHIS eTool was introduced to capture daily health service data at the facility level. This initiative aimed to reduce the time spent on manual calculations and human error. The DHIS software has since expanded to cover hospital data, emergency medical services data, emergency health services data, client satisfaction surveys, core standards and measures of quality of care, survey data sets, and data sets related to infrastructure and populations. It has proven to be a reliable tool for planning, budgeting, health service management, monitoring, and evaluation at all levels of the South African healthcare system (Department of Health, 2012)[216].

Data management challenges

The DHIS software faces challenges in data sourcing, storage, management, and feedback, including limitations in patient-level analysis due to aggregated data-storage. Additionally, absence of web-based versions in some provinces requires data exportation for national reporting, leading to inefficiencies (Department of

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[216] Department of Health, (2012). *'District Health Management Information System (DHMIS): Standard Operating Procedures: Facility Level.'* Available at: https://www.hst.org.za/publications/NonHST%20Publications/Facility_Level%20DHMIS_SOPs.pdf

Health,2011)[214]. Lack of fixed cut-off dates for data input results in inconsistent reporting, while integration issues persist among various hospital information systems (Department of Health,2011)[214].

Other challenges include limited analytical capabilities of systems like the transversal Personnel Administration System (PERSAL) records staff information and the Basic Accounting System (BAS), ineffective data exchange between systems, absence of a unified data repository, and lack of standardisation in data collection tools. Poor feedback mechanisms exacerbate the challenge of data standardisation and integration across different levels of the healthcare system (Department of Health,2011)[214]. Data is not systematically used to determine expenditure allocation, making comparisons across provinces difficult. Data exchange between systems is ineffective or non-existent (e.g., PERSAL and BAS with DHIS), and a single data repository that integrates routine health data, population-based data (e.g., vital statistics, Census, survey data), and relevant non-health data from other sectors does not exist (Department of Health,2011)[214].

Moreover, there is a lack of standardisation of data collection tools, and there are many registers that are not controlled at national and provincial levels. Poor data feedback mechanisms between national and provincial levels and between provincial, district, and sub-district levels also need to be addressed (Department of Health,2011)[214].

ACTS GOVERNING THE PROCESSES OF DATA COLLECTION

There are various acts governing the process of data collection, and they influence the way healthcare information is expected to be collected.

Table 18: Acts informing the collection of health information[214]

ACT	KEY COMPONENT RELATING TO HEALTH INFORMATION
NHA (ACT 61 of 2003)	• The NDOH shall facilitate and coordinate the establishment, implementation, and maintenance of the information systems by provincial departments, district health councils, municipalities, and the private health sector at national, provincial, and local levels to create a comprehensive national HIS • The minister may for the purpose of creating, maintain and adapting databases within the national HIS prescribe categories for data collection and submission and the manner and format in which and by whom the data must be compiled, collated and submitted to NDoH • Future development of the National Health Management Information System will include incorporation and integration of health information from the private sector. The promulgation of Chapter 9 of the NHA of 2003 will provide the legal framework for this process.
Births and Deaths Registration Act (Act 51 of 1992)	• Department of Home Affairs (DHA) legislation governs notification of registration of births, deaths and stillbirths • Births are to be notified at the DHA within 30 days • Death due to natural causes, stillbirths and deaths occurring outside of the country are also to be registered at the DHA
Statistics Act (No.6 of 1999)	• The Statistician General is responsible for all matters governing statistics in SA such as formulating quality criteria and establishing standards, classifications, and procedures for statistics.

ACT	KEY COMPONENT RELATING TO HEALTH INFORMATION
	• The Statistician General is also responsible for promoting coordination of the procedures of official national statistics to ensure harmonisation of information and avoid duplication
Promotion of Access to Information Act (no. 2 of 2000)	• Gives effect to the constitutional right of access to data held by the state and that is required for exercising protection of any rights • Additionally, it provides a framework for requesting such data and information • Aims to foster a culture of transparency and accountability • The DHIS predominantly contains aggregated public health data that should, within the parameters provided in this policy be available to all South Africans
Public Finance Management Act (No. 1 of 1999)	• The accounting officer of an institution must establish procedures for quarterly reporting to the executive authority to facilitate effective performance monitoring, evaluation, and corrective action
Public Finance Management Amendment Act of 1999 (No. 29 of 1999)	• The accounting officer for a department must submit within five months of the end of a financial year to the relevant treasury/executive authority: (a) an annual report on the activities of the department, (b) the audited financial statements for the financial year and (c) the Auditor-General's report on those statements.
Public Audit Act of 2004 (No.25 of 2004)	• An audit report must reflect such opinions and statements as may be required by any legislation applicable to the auditee but must reflect at least an opinion or conclusion on the reported information relating to performance of the auditee against objectives set out in the audit.
Government wide M&E guidelines (2007)	• Developed by the presidency and presents an overarching policy framework for M&E in the South African government • Consists of four parts: understanding M&E, the government wide ME system, M&E at institutional level, implementation of the system • Clarifies M&E concepts, principles and processes and describes the purposes and processes of M&E activities in Government • Provides guidance on how M&E should be aligned and linked to managerial systems such as planning, budgeting, project management and reporting • Prescribes the type of data to be submitted but is more flexible about data collection processes
DHMIS policy (2011)	• Provides a regulatory framework in terms of the NHA of 2003 • Developed by the NDoH and focuses on seven priority areas: health information coordination and leadership, indicators, data management, data security, data analysis and information products, data dissemination and use, HIS resources • States that health managers at all levels of the healthcare system should assume ownership of the HIS • Aims to standardise implementation for the DHMIS and to clarify roles and responsibilities of each level of the health system • Objectives are to strengthen M&E as well as the use of information in policy and programme planning • Clarifies the roles and responsibilities of each administrative level and category of staff • Ensures data security and integrity • Policy is to be used in conjunction with a set of standard operation procedures produced in a separate document
National Evaluation Policy Framework (2011)	• Provides the basis for a minimum system of evaluation across government. Its main purpose is to promote quality evaluation which can be used for learning to improve the effectiveness and impact of government public entities reflecting on what is working and what is not and revising their interventions accordingly.

ACT	KEY COMPONENT RELATING TO HEALTH INFORMATION
	• Seeks to ensure that evidence from evaluation is used in planning, budgeting, organisational improvement, and policy review, as well as ongoing programme and project management to improve performance. Provides a common language for evaluation in the public sector. • While it provides for a government-wide system, the focus is on evaluations specified in the national evaluation plan.

The table above shows that South Africa has legislation and policies in place to support information management. However, there is a significant gap between policy and implementation. Therefore, it is crucial to identify the key challenges that hinder the translation of health sector policies into practice. These challenges include legislative and policy challenges, governance and leadership challenges, and resource, software, and hardware challenges.

DEVELOPMENT OF THE DHMIS POLICY (2011)

The goal of the policy is to standardise implementation of the DHMIS and create uniformity across South Africa. The objectives of this new policy are (Department of Health,2011)[214]:

Ownership & governance: Overall ownership of the DHMIS resides with the Director General (DG) at a national level, heads of department at provincial level and the district manager at district level. The National Health Information Systems Committee of South Africa (NHISSA) is responsible for ensuring that all health information systems adhere to national guidelines and specifications.

Financing: Provincial and district heads are responsible for ensuring that finances and systems are in place for sourcing adequate resources at all levels. However, disadvantages lay in a lack of guidelines of how the costing should be done or how much of the total budget should be allocated towards managing the health information system.

Staffing: Different staff categories based on job descriptions should be appointed at different levels across the health system. Different positions include data capturers, health information officers, and health information managers. Limitations with the policy is that it does not provide guidance on training or career progress mapping.

Equipment and ICT: All managers need to ensure the required equipment is available at all levels. National and provincial ICT units will be responsible for the acquisition of hardware and software for data storage, standardisation, maintenance and upgrading. A gradual shift from the server to web-based solutions is advised.

Indicators for monitoring and evaluation of the policy[214]

- The NDoH is responsible for developing and monitoring the national indicator dataset (NIDS) and its associated data elements.
- A dataset incorporating relevant data procured by other sectors will be developed.
- The NIDS will be revised every two years. Any additional data requests must be submitted to the DG along with sufficient motivation for its inclusion. The DG is responsible for communicating any changes to the NIDS to provinces 6 months prior to commencement of the next financial year.
- Provinces can also make specific provincial indicator set requests which must be submitted to the provincial HoD at least 3 months prior to the start of the new financial year.
- The DG is responsible for ensuing annual targets are developed for all indicators and adapted to each province and district.

Data use, management, and feedback encompass several aspects, including data collection tools, data flows, quality assurance, data analysis and dissemination, and the use of data. The National Information Cluster will lead the process of streamlining and standardising data collection tools to be used across all provinces. SOPs will be implemented to guide the process and timelines for data submission, with all data being signed off by their respective management before submission. Routine data submission deadlines will be reduced to 45 days from 60 days (Department of Health,2011)[214]. Data quality assurance will be ensured by using eight dimensions of data quality, including relevance, integrity, timeliness, accessibility, reliability, completeness, accuracy, coherence, and comparability. Provincial HODs will analyse data reported in their provinces during each reporting period. Two types of reports will be produced, a standardised quality report, and a standardised performance report for all levels. Additionally, a web-based reporting system will be developed (Department of Health,2011)[214].

With respect to dissemination, managers at all levels in the health system must ensure that data are reviewed and used in the development of legislated strategic plans. The georeferencing of public health establishments will be accomplished by the NDoH to assist with data analysis and feedback (Department of Health,2011)[214]. The DHIS policy emphasises leadership and stipulates that HIS ownership lies with departmental heads, with M&E forming part of performance agreements with these managers. A comprehensive health statistics publication reflecting the performance of the entire health system will be produced by the NDoH, disaggregated by province (Department of Health,2011)[214].

While comprehensive policies have been developed, implementation efforts have not been satisfactory, as many stakeholders have reported poor data collection within the DHIS from a national perspective. The accuracy of data rests on the facility itself, which must complete it as accurately as possible (Department of Health,2011)[214].

HOW IS DHIS DATA USED

The DHIS system provides data that can be used for trend analysis, outbreak planning, budgeting, monitoring, and evaluation. The trend analysis conducted across Theme 1 and 2 provide examples of this. The data collected and compiled monthly at a national level can also be used by facility managers to conduct detailed trend analysis with their data collection teams for service provisioning planning at their specific facilities. Additionally, environmental health officers can use this data to plan resources for health outbreaks, and the underlying environmental situation. Having an overview of service usage and the ability to analyse trends over time can aid

in planning, budgeting, health service management, monitoring, and evaluation of service provisioning at all levels (Department of Health,2011)[214]. Additionally, DHIS data feeds into other useful reports and statistics such as the District Health Barometer report, StatsSA publications on HIV and TB trends, as well as the Annual Performance Reports of Provinces.

During interviews, mental health stakeholders in Gauteng[141] and the Northern Cape[217] indicated that they use DHIS inputs to develop an overview of their service provisioning and demand. This information is used to understand how to best respond to demand. Provinces are taking steps to use the data to better plan their services. However, there is room for national government to develop more user-friendly information pieces from this available data which include:

- Developing a monthly report which speaks specifically to mental health services, however, DHIS2 is expected to be able to deliver such inputs; therefore, it may be easier than expected to do this.
- Identify common denominators to health care problems such as age and locations and use this information to plan, implement and evaluate activities to improve health outcomes.
- The system could flag struggling and best practice facilities and create opportunities for facilities to learn from each other.

Certain challenges, as discussed in "data management challenges" section, prevent DHIS data from being as effective as possible for evidence-based decision-making. Evidence-based decision-making is important because it allows us to better utilise available resources and knowledge, by aggregating relevant information in a way

In the context of mental health, evidence-based decision-making holds significant importance, enabling informed choices and effective interventions. This entails the necessity of acquiring routine, high-quality data on patients and their social determinants of health to comprehend individual patient journeys and devise personalised health plans. Understanding the availability of human and financial resources and utilising them for resource planning aids in evidence-based resource allocation and serves as evidence of need. Tracing medication inventory allows for timely management of hospital inventory, ensuring adequate supply levels[217].

that is useful for evaluations. This approach involves considering knowledge from multiple sources, using it to direct goals and actions with more certainty and updating knowledge over time to adjust to actions and decisions accordingly (Shafaghat et. al, 2022)[218].

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[217] Stakeholder Interview, 2023

[218] Shafaghat, T., Bastani, P., Nasab, M.H.I. *et al.* A framework of evidence-based decision-making in health system management: a best-fit framework synthesis. *Arch Public Health* **80**, 96 (2022). https://doi.org/10.1186/s13690-022-00843-0

Best Practices

The WHO AIMS framework[219] for mental health together with the South Africa Mental Health Atlas 2020 report[14] was used to understand what data is needed to undertake evidence-based decision-making. Domain 6 of the WHO AIMS framework is "Monitoring and Research" which comprises of two sub-domains:

- 6.1 Monitoring mental health services
- 6.2 Mental health research

The WHO has outlined criteria under each sub-domain that can be used to determine a country's effective utilisation of data and research to facilitate decision-making. Although there is no scoring system in place, comparing South Africa's progress to a country that prioritises mental health can be helpful. In this regard, Australia was used as a reference for analysis.

The Mental Health Atlas for South Africa in 2020[14] meets the criterion of having Mental Health-specific data compiled in the last two years for the public sector. This is measured by the AIMS framework and is also the case for Australia. Therefore, South Africa is on par with Australia in this regard. However, it is important to note that there are concerns around the quality of this data.

According to the 2020 Mental Health Atlas report[14], South Africa had 165 research papers published in 2019. This number has increased by 3 papers since 2016. However, this research only accounts for 6.89% of the total health research output in the country, and 27.6% of the total mental health output in the Sub-Saharan region. In contrast, Australia has produced 1074 mental health research papers, which is 6.5 times more than South Africa. This research makes up 12% of the health research output within the country and 30% of the total health output in the region.

Objective 4 of the WHO's Mental Health Action Plan (2013-2020; extended to 2030) aims to improve mental health information systems, evidence, and research. This objective suggests that countries should collect data on human resource levels, medicine availability, and hospital admissions, and that this data should be categorised by various socio-economic groups like gender, age, geography, and race/ethnicity. A good example of data collection on socio-economic groups and use of this data for evidence-based decision-making is shared in the case study below:

HeadStart Programme Use case[220]

HeadStart is a UK based school programme which uses the Wellbeing Measurement Framework Survey as part of its annual evaluations to track programmatic progress. The survey is amended according to each schooling programme needs and the beneficiaries are included in determining relevant survey questions. The response rates are generally over 85% (over 30,000 pupils respond each year) and each school is then provided with an

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[219] WHO, (2005). *'WHO-AIMS Instrument Version 2.2.'* Available at: https://www.who.int/publications/i/item/WHO-MSD-MER-05.02
[220] University College London: Evidence Based Practice Unit, (2022). 'Making best use of pupil mental health and wellbeing data.
'. Available at: https://www.ucl.ac.uk/evidence-based-practice-unit/headstart-learning-team/learning-updates-case-studies/case-studies

online report which shows how the mental wellbeing of children in their schools compares to others in the HeadStart programme.

Based on the demographic analysis of the survey results, it showed that girls in Year 9 are struggling with anxiety and based on this information a 12-week course on self-esteem and anxiety with Year 8 girls was implemented as it was felt that preventative methods would be more effective and help with the transition into Year 9. Importantly the survey results are shared in assemblies with all pupils, reinforcing how important mental health is and allowing students to understand how the school is responding to these results.

South Africa's current mental health data is insufficient for evidence-based decision-making due to the following reasons:

- The data being collected is not enough to properly evaluate the quality of care (for example through regular client satisfaction surveys or protocol checklists) or track the progress of mental health patients' overall well-being and dignity (in-patient and out-patient wellbeing over time is not tracked) or inform policies and practices. This means that it is impossible to assess progress or identify and address errors, which is a pressing issue that needs to be addressed urgently.
- Patient-level clinical data is not currently collected nationwide in South Africa. However, the National Department of Health is in the process of developing the Health Patient Registration System (HPRS) linked to a shared electronic medical record.
- Current mental health data is incomplete and insufficient, lacking disaggregation by socioeconomic groups.

In an interview discussion with a relevant stakeholder on using data for decision-making it was noted that South Africa should focus on developing electronic profiles for patients, which will allow for health information, such as patient mental well-being to be easily related to patient socioeconomic and demographic variables.

8. DISCUSSION

THIS SECTION WILL INTERPRET & DESCRIBE WHAT THE FINDINGS OF THIS SITUATIONAL ANALYSIS MEANS FOR MENTAL HEALTH IN SOUTH AFRICA

The research findings reveal a concerning reality: mental health is not receiving the prioritisation it warrants in South Africa. There is insufficient data available on the prevalence and incidence of mental and neurological disorders which complicates efforts to gauge the true extent of the issue. Even though some biased estimates suggest that 80% of individuals with mental health issues in underdeveloped countries remain undiagnosed and untreated, it is difficult to get reliable estimates[23]. Mental health conditions are on a continuum and can change over time. According to the Wits probable depression study[6], 25.7% of South Africans will experience depressive disorder symptoms at least once in their lifetime.

Significant disparities in mental health prevalence exist across regions and demographic groups within South Africa. Incidence and prevalence rates differ across provinces within South Africa with the Northern Cape displaying the highest rates of depression and anxiety, the Free State showing the lowest depression rates, and KwaZulu-Natal with the lowest anxiety prevalence. Urban and rural rates also vary with metropolitan areas showing a depression prevalence of 53% compared to 23.8% in city/town settings and 22.5% in rural areas. Limited availability of mental health facilities in rural regions may restrict access to services, potentially increasing the prevalence of mental health issues[17].

Vulnerable populations such as children, adolescents[20], mothers, the LGBTQ+ community[80-83]and individuals facing socio-economic challenges are particularly at risk. The risk factors associated with mental health issues are well-documented in the literature. According to the sources cited in this report, individuals aged 15-30 years are more likely to experience mental health issues than other age groups[18]. During the perinatal period, MNS disorders affect 20-40% of women, and this is often influenced by socio-economic factors such as poverty, violence, and limited access to services. The experiences of mothers can also affect their children, who may be more prone to developing MNS disorders. It is important to have targeted interventions and programmes that focus on early detection, prevention, and mental health awareness for this group of individuals[46-47].

The presence of other comorbidities increases the chances of individuals developing mental health issues because of coping with a life-threatening illness. Individuals with an underlying condition as well as mental health issues often fall into a spiral leading to relapses and failure to adhere to medication which only makes their condition worse. This can be seen by the fact that 40% of the HIV population in South Africa suffer from mental health issues[67]. Furthermore, disabled individuals who are severely excluded and experience stigma are equally likely to develop mental health issues[75-78].

The interplay between poverty, unemployment and mental health is particularly notable, with each exacerbating the other in a vicious cycle. Stigma surrounding mental health, which spans across all socio-economic factors

and demographics, often results in feelings of shame that prevent individuals from understanding their condition, seeking necessary care, and receiving support[87-93].

The Covid-19 pandemic has further worsened these disparities, amplified stressors, and exacerbated existing mental health disparities. The Covid-19 pandemic has not only posed a serious health emergency but also led to poor economic outcomes. Many individuals lost their jobs, and incomes, and ended up in poverty as a result. The relationship between poverty and mental health is cyclical, which makes it particularly challenging for unemployed and impoverished individuals to manage their mental well-being[5,56,57,93].

Other factors that increase the risk of mental and neurological disorders include family history of mental health, childhood adversity, social isolation, and stressful life events. Children are more likely to develop mental health issues when one of their parents experienced mental health issues, and this effect is greater when it is the father experiencing mental health issues. Other childhood adversities such as exposure to abuse also impact on the child's mental health into adulthood. Covid-19 provides a good example of both social isolation and a stressful life event and has shown how these events can influence an individual's state of mind[93-95].

South Africa's dual public-private healthcare model faces significant challenges, primarily due to resource constraints. South Africa is trying to improve the quality of mental healthcare services through a collaborative and integrated approach. However, progress in this area has been hindered by a lack of human and financial resources. The country is facing a significant shortage of healthcare workers, which is caused by the divide between the public and private healthcare sectors and the high rates of immigration among healthcare workers. To address this issue, South Africa needs to develop a plan of action, in collaboration with higher institutions, to increase the number of healthcare workers joining the workforce. Simultaneously, efforts should be made to improve the working conditions of healthcare workers, which will help in relieving their work burden. It is crucial to ensure that there is adequate infrastructure and resources available to create better working conditions[95]. As mentioned in the Covid-19 case study earlier, many healthcare workers felt anxious because there was limited PPE gear available, and they feared they could infect their families. The government needs to provide healthcare workers with the appropriate equipment and infrastructure to perform their jobs effectively[95].

Service delivery in South Africa is different across different provinces and the disparities are wide. Provinces such as Gauteng, KwaZulu-Natal and the Western Cape have much more human and financial resources available. These resources influence the ability to develop and acquire more facilities and equip facilities with the necessary staff and equipment. This influences what healthcare looks like in the province. Provinces such as the Northern Cape, Northwest and Mpumalanga have very few resources and limited capacity to service their populations when compared to Gauteng and the Western Cape. Provinces receive budgets based on their population headcount, however, there is a clear need to use additional metrics in budget determination as provinces such as the Northern Cape, Northwest and Mpumalanga are severely under-resourced and require additional budget[17]. Government has instituted the NHI conditional grant to provide additional funding to support provinces in acquiring more appropriate human resources.

Many of the district hospitals across provinces lack appropriate resources and cannot comply with standard treatment guidelines. These facilities do not meet the recommended standards and norms for treating individuals with MNS disorders, but they are unfortunately the only available option for such patients. There is a lack of proper screening for individuals in communities who suffer from MNS disorders or are predisposed to such disorders. The reason behind this is the shortage of staff who are skilled in the process of screening. Moreover, the existing staff are overburdened with work, which makes it difficult for them to carry out the screening process effectively. As a result, many individuals continue to remain undiagnosed and untreated[17].

Patients who are suffering from severe mental, neurological, and substance use disorders (MNS) often need to be referred from primary healthcare to more specialised levels of care. However, sometimes healthcare workers fail to recognize when a referral is necessary, and as a result, patients are left at PHC facilities. Additionally, in some cases, specialised facilities may not have enough capacity to accommodate all the patients who require treatment[97].

It is common for mental health drugs to be out of stock in many parts of the country, including provinces such as Gauteng that have larger budgets for acquiring medication compared to others. Inappropriate planning and medicine shortages are cited as the reasons for these stockouts. These stockouts have had a significant impact on the lives of many Mental Health Care Users (MHCUs), resulting in relapses for some[136-140].

South Africa is facing a shortage of human and financial resources, which has resulted in a decline in the quality of care for mental health patients. Private healthcare is not affordable for most South Africans, leaving many with untreated or poorly treated mental health conditions[17]. To address this, the Ideal Clinic project was introduced, which sets out the requirements for clinics to achieve ideal status. However, implementation and monitoring of this project have been inadequate, and many facilities have not achieved ideal status[127,129].

Task-sharing[177-178] and integrating mental health into primary healthcare have been proposed as solutions. However, healthcare workers are already overburdened, and some may not want to provide mental health services due to stigma attached to it. Additionally, staff need to be trained on how to screen, assess, and develop treatment plans for mental health patients.

Integrating mental health into primary healthcare can improve access and convenience for patients. Trials have shown positive results with HIV/TB patients who also suffer from mental health issues. However, there are barriers to integration, such as a lack of staff and a poorly functioning referral system. Continuous investment in upskilling healthcare staff is imperative for ensuring equitable access to integrated mental health services, particularly in primary healthcare settings.

To support the improvement of mental health in South Africa, the National Mental Health Framework and Strategic Plan has proposed key structures and committees be put in place to drive this change. These structures include the development of provincial mental health directorate, district specialist mental health teams as well as other relevant bodies such as a mental health review board. While there has been progress in this regard for

example; all provinces have mental health review boards, three have mental health directorates established and six now have district specialist mental health teams, some provinces still lag behind due to poor secretariat support and other resource barriers. [2,13,104,120].

South Africa's allocation of healthcare expenditure towards mental health remains a critical aspect of its healthcare budget, constituting only 5% of the total healthcare expenditure. Significant disparities exist among provinces regarding funding distribution, with some provinces receiving disproportionately less funding than others on a per capita basis. The underinvestment in certain regions may limit access to early intervention and support services, contributing to the burden on tertiary care facilities[17].

Investing in mental health is crucial for the well-being of South Africans and the economy. Mental health costs South Africa billions of dollars in productivity each year. The return on investing in mental health is high, with healthy individuals being productive individuals. Collaboration between the public and private health sectors, NGOs, and CBOs can help improve mental health. Public-private partnerships and partnerships with higher education institutions can also help develop a more appropriate healthcare workforce[199-202].

South Africa has extensive policies regarding mental health from 1994 to 2023. These policies have evolved towards a human-rights, integrated, and collaborative approach. They are well aligned with WHO guidance, but the implementation of these policies has been lacking. The Mental Health Act of 2002, while aligned with WHO standards, lacked implementation as provinces found it unclear to implement in their contexts. To address this, the government established national strategic frameworks and plans as guidelines for provincial departments to implement. These frameworks highlighted the imbalance across provinces, as well as the urban/rural divide in service provision. While some provinces have developed and implemented such strategies, many provinces have failed to contextualise national inputs into a provincial strategy. Only five out of the nine provinces have developed provincial strategic plans and only one is costed. Barriers to policy implementation include poor dissemination, insufficient political support and funding, lack of collaboration across government sectors, no pilot projects to demonstrate impact and learn iteratively, and limited interactions amongst stakeholders. South Africa has worked towards eliminating these barriers through pilot sites for NHI and advocating for multi-sectoral working groups to ensure appropriate collaboration across government departments[207].

The introduction of NHI does not provide information on how priority setting will be done and its influences, as well as how the package of services will be developed. This is concerning as the budget allocated to mental health should be aligned with appropriate suggestions, such as those discussed in the investment case, and the determination of the package of services should involve key stakeholders with an understanding of mental healthcare service delivery[214-216].

Data plays a crucial role in understanding mental health prevalence, planning service provision, and informing policy changes. In South Africa, the availability of comprehensive mental health data is limited, posing challenges for evidence-based decision-making. The primary source of data, the district health information system (DHIS), collects information at the facility level. Concerns in using DHIS data include a lack of

standardisation with some facilities using the web-based version and others using paper based, integration with other relevant departments and aggregation at a level that limits patient-level analysis. National government needs to enforce consequences for poor data collection. Currently, these consequences are not enforced effectively as data quality issues still occur[214]. There are also opportunities for provinces to collect more nuanced data based on their specific needs through provincial indicator data sets.

Improving data systems for tracking mental health prevalence, incidence, treatment over time is crucial for South Africa to move towards evidence-based decision-making. A comprehensive data system can facilitate trend analysis, resource allocation, and service planning, ensuring that mental health services are targeted effectively and accessible to those in need. Establishing a robust monitoring and evaluation system is key for assessing programme performance and guiding policy adjustments. Tracking outcomes can allow the country to update and amend policies around service provisioning to ensure that services are effective and targeted to patients at-risk in modalities that are easily accessible to them for the greatest impact[218-220].

9. STUDY LIMITATIONS

THIS SECTION WILL DESCRIBE THE RLEVEANT LIMITATIONS & CAVEATS WHICH NEED TO BE CONSIDERED WHEN INTEPRETING THE FINDINGS OF THE REPORT

This report is based on publicly available data, information obtained through interviews with stakeholders as well as information from DHIS on mental health variables collected across all districts in South Africa. Nonetheless there are a few limitations in this study that should be noted:

- Data on prevalence and incidence are limited in their usefulness due to the use of various estimations, tools, and measures used to understand mental health. Creating challenges in understanding the true extent of the burden of disease.

- Overall, the study lacked inputs from the Provincial Mental Health and Substance Abuse programme managers across all nine provinces as the strategic teams organising and leading provincial level mental health programmes.

- Reporting on mental health care expenditure in department of health annual reports differs in granularity across provinces presenting challenges in determining how funding is allocated for mental health care provisioning. Additionally, there is limited updated information from provinces on funding allocated to mental health beyond psychiatric hospitals.

- Data on socio-economic determinants have been sourced from a variety of studies based on population samples, rather than the actual Mental Health Care Users (MHCUs) in South Africa to date, resulting in limitations in understanding who the at-risk populations are in South Africa.

- Limited information on the progress of task-sharing and integration at a national and provincial level which presents challenges in assessing the level of progress of the country with respect to these approaches.

- Limited updated information on human resources per province as well as limited updated information on the key structures formed across provinces, such as filling the Mental Health Provincial Directorate Role. Therefore, understanding the true extent of human resources in mental health is limited. Additionally, information on whether DMHSTs are evaluated was not included in this study.

- Limited information on the extent of policy implementation at a provincial level, including whether the province has developed a province-specific mental health plan stemming from the National framework hampering the ability of the report to understand progress of provinces from a policy implementation perspective.

It is important to take these limitations into consideration when reviewing the results of this report for any intended purposes.

10. CONCLUSION

THIS SECTION OUTLINES THE KEY FINDINGS FROM THE REPORT

The purpose of the report is to analyse mental health in South Africa by examining four key themes. These include: (1) understanding the prevalence and incidence of mental and neurological disorders in South Africa; (2) understanding the service providers of mental health care in the public sector across government, NGO and CBO facilities, as well as their service delivery packages and mechanisms of delivery; (3) reporting on mental health policy changes between 1994 and 2023 and their implementation across provinces; and finally (4) reporting on the availability and quality of mental health data in South Africa.

The prevalence of mental health issues is increasing globally, particularly in South Africa, where both lifetime and 12-month prevalence rates are higher than the global average based on 2003-2004 data. These rates are likely to be even higher today due to the impacts of stressful life events and social isolation from Covid-19. Depression and anxiety rates vary across provinces based on contextual factors such as income, race, gender, age, and cultural contexts. Therefore, each province is encouraged to provide services in accordance with national legislation but contextualized to their specific setting.

When observing the risk factors associated with individuals developing mental health issues, certain population groups are at greater risk. These include children and adolescents, childbearing and child-rearing women, individuals suffering from poverty, unemployment and low-income levels, individuals with other communicable and non-communicable diseases, disabled individuals, LGBTQ+ individuals, and individuals with family mental health history, adversity or experiencing stigma. In short, the most vulnerable population groups in society. By understanding these mental health determinants, we can gain a full understanding of the drivers of mental health.

Describing the different service providers and their packages of services through a geographical lens allowed for an understanding on which provinces are providing sufficient resources towards

> **INSIGHTS**
> - RSA prevalence rates are increasing.
> - Covid19 pandemic context is a significant risk factor.
> - Vulnerable population groups are most at risk.
> - Considering geographical (provincial) variances is critical.
> - Burden of disease insights must be viewed in context of available resources.
> - RSA mental health policies are aligned with international best practices.
> - RSA needs better data to enable evidence-based decision making to lower prevalence rates over time.

mental health care delivery and which provinces require support in their delivery. Overlaying prevalence and supply factors provided interesting insights, showing that provinces such as Gauteng, Western Cape, and KwaZulu-Natal are sufficiently resourced (with human and financial resources) compared to other provinces. However, provinces such as the Northwest, Northern Cape, and Mpumalanga have fewer resources, albeit smaller populations to serve, but when considering the risk factors, these provinces are insufficiently resourced.

Provinces with fewer financial and human resources are disadvantaged in providing adequate services for mental health, leading to lower PHC mental disorder treatment rates, smaller investments in infrastructure and technology, challenges in developing key structures and achieving ideal clinic status. Provinces such as the Free State and Eastern Cape, while having more facilities available than provinces such as Northern Cape, Northwest, and Mpumalanga, also tend to fall within the lower performing provinces. Financial and human resources are key drivers of performance, with many provinces citing limited resources as barriers to integrating mental health into PHC and task-sharing approaches, despite these approaches being introduced due to limited resources.

National and provincial departments of health can collaborate to understand how existing resources can be redistributed and used more efficiently based on the province's specific needs, with national providing the appropriate guidance and training for provinces to implement evidence-based decision-making.

Historically, policies have played an important role in shaping the structure of mental health care service delivery. However, they have lacked implementation due to limited resources. Although all mental health policies in South Africa are aligned with international best practice in both the process of development and ratification, policies have consistently lacked adequate implementation. Policy implementation requires sufficient human, financial, and technical resources to support the establishment of key structures, implementation of programs, and monitoring and evaluation of progress.

Finally, there is very limited, reliable, and consistent data on the mental health prevalence and incidence population in South Africa. The most consistent data is the DHIS, and even this dataset has its own set of challenges related to data quality. This data does not include information on service quality, or track patients on their treatment journey over time and across facilities. These limitations impede the ability of provincial departments of health to undertake evidence-based decision-making to improve interventions based on real patient data.

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APPENDICES

Appendix A

STUDY NAME	DATE	DISEASES COVERED	% PREVALENCE	SAMPLE SIZE
Factors associated with prevalence of mental disorder in people living with HIV/AIDS in South Africa	2008	Depression (HIV/AIDS)	43.7%	900 HIV patients
DSM-IV personality disorders and their axis I correlates in the South African population	2008	Personality Disorder	6.8%	4 315
Life stress and mental disorders in the South African stress and health study - PubMed (nih.gov)	2009	Mood Disorder	15.8%	4 351
Life stress and mental disorders in the South African stress and health study - PubMed (nih.gov)	2009	Anxiety Disorder	8.1%	4 351
Life stress and mental disorders in the South African stress and health study - PubMed (nih.gov)	2009	Substance Use Disorder	1.8%	4 351
Life stress and mental disorders in the South African stress and health study - PubMed (nih.gov)	2009	Impulse Disorder	3.0%	4 351
The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders - PubMed (nih.gov)	2009	Anxiety Disorder	15.8%	4 351
The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders - PubMed (nih.gov)	2009	Substance Use Disorder	13.3%	4 351
The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders - PubMed (nih.gov)	2009	Mood Disorder	9.8%	4 351
The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders - PubMed (nih.gov)	2009	Major Depressive Disorder	9.8%	4 351
The barriers preventing effective treatment of South African patients with mental health problems	2010	Depression	30.0%	331
The barriers preventing effective treatment of South African patients with mental health problems	2010	Bipolar Disorder	40.0%	331
The barriers preventing effective treatment of South African patients with mental health problems	2010	Schizophrenia	13.0%	331
Global Burden of Disease	2016	Depression	15.9%	-
The relationship between childhood adversity, recent stressors, and depression in college students attending a South African university - PubMed (nih.gov)	2018	Depression (Early Childhood Adversity)	16.1%	686
Perinatal depression among mothers in a South African birth cohort study: Trajectories from pregnancy to 18 months postpartum — North-western Scholars	2019	Depression (Perinatal)	50.0%	831

STUDY NAME	DATE	DISEASES COVERED	% PREVALENCE	SAMPLE SIZE
Prevalence and risk factors associated with postnatal depression in a South African primary care facility - PubMed (nih.gov)	2020	Depression (Postnatal)	38.8%	227
National Income Dynamics Study (NIDS) – Coronavirus Rapid Mobile Survey (CRAM)	2021	Depression	40.0%	-
The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa	2022	Depression	25.7%	3 402
The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa	2022	Anxiety Disorder	17.8%	3 402
Comorbidity of mental ill-health in tuberculosis patients under treatment in a rural province of South Africa: a cross-sectional survey	2022	Anxiety Disorder (TB)	48.0%	197
Comorbidity of mental ill-health in tuberculosis patients under treatment in a rural province of South Africa: a cross-sectional survey	2022	Depression (TB)	38%	197
Comorbidity of mental ill-health in tuberculosis patients under treatment in a rural province of South Africa: a cross-sectional survey	2022	Substance Use Disorder (TB)	43%	197

Appendix B

The NIDS data includes 60 different facility types. For high level reporting purposes, the 60 facility types were mapped to 9 facility types:

1. Clinic
2. Community Centre
3. District Hospital
4. EHS
5. Outreach
6. Rehabilitation
7. Hospital
8. Private
9. Specialised Psychiatric Hospital

The mapping of 60 facility types down to 9 facility types can be seen in the table below. A facility was mapped as "No" when it was not deemed as an appropriate medical facility.

Facility Type	Mapped
Clinic	Clinic
Community Day Centre	Community Centre
Community Health Centre	Community Centre
Correctional Centre	Community Centre
District Hospital	District Hospital
EHS DM Service	EHS
EHS LG Service	EHS
EHS Port Health Service	EHS
EHS Prov Service	EHS
EMS Station	EHS
Environmental Health Service	Excluded
General Practitioner	Excluded
Health District Office	Excluded
Health Education Service	Excluded
Health Post	Outreach
Health sub-District Office	Excluded
High Transmission Area	Excluded
Home Based Care	Rehabilitation
Laboratory	Excluded
Long-term Care	Rehabilitation
Malaria Unit	Excluded

Facility Type	Mapped
Military Hospital	Excluded
Mobile Service	Outreach
National Central Hospital	Hospital
Nurse Practitioner	Excluded
Pharmacy	Excluded
Private Facility	Private
Private Hospital	Private
Private Maternal Health	Private
Private Ward	Private
Province	Excluded
Provincial Tertiary Hospital	Hospital
Quarantine Site	Excluded
Regional Hospital	Hospital
Satellite Clinic	Clinic
Sickbay	Excluded
Specialised Centre	Community Centre
Specialised Clinic	Clinic
Specialised Hospital Other	Excluded
Specialised Psychiatric Hospital	Specialised Psychiatric Hospital
Specialised TB Hospital	Excluded
Specialist	Excluded
Stock Distribution Point	Excluded
University	Excluded
WC Community Health Centre (After hours)	Community Centre
WC Community Health Centre / Clinic	Community Centre
WC Hospice	Excluded
WC Medical Centre	Community Centre
WC Mental Health Centre	Community Centre
WC Midwife Obstetrics Unit	Excluded
WC Occupational Health Centre	Centre
WC Pharmacy Depot	Excluded

Facility Type	Mapped
WC Pharmacy/Clinic	Clinic
WC Place of Safety	Excluded
WC Rehabilitation Centre	Community Centre
WC Reproductive Centre	Community Centre
WC School Health Team	Outreach
WC Special Clinic	Clinic
WC Step Down Facility	Excluded
WC Surgical Centre	Community Centre

Appendix C

	EC	FS	GT	KZN	LP	MP	NC	NW	WC	National
Psychiatrists	0.1	0.59	0.51	0.12	0.15	0.08	0.4	0.12	0.89	0.31
Sessional psychiatrists	0.02	0	0	0.06	0	0	0	0.03	0	0.02
Psychiatry registrars	0	0	0	0	0	0	0	0	0.12	0.01
Child psychiatrists	0	0.04	0.02	0	0	0	0	0	0.08	0.02
Child psychiatry registrars	0	0	0	0	0	0	0	0	0.08	0.01
Psychologists	0.87	0	1.38	0.61	1.22	0.7	3.28	0.46	1.22	0.97
Psychologist (community service)	0.2	0.42	0.58	0.17	0.09	0	0.5	0	0.3	0.26
Psychologist intern	0.02	0.17	0.39	0.09	0.11	0.05	0.6	0	0.16	0.16
Medical officers	18.91	15.73	17.97	20.98	16.01	14.8	24.76	15.35	19.93	18.3
Medical officer (community service)	2.07	2.73	2.38	2.16	2.82	4.08	7.06	5.15	4.07	2.98
Medical officer (intern)	5.44	7.32	8.99	7.79	3.99	3.71	6.36	6.77	6.52	6.71
Occupational therapist (grades 1–3)	1.38	0	1.62	0.79	2.5	1.45	3.68	0.98	2.61	1.53
Occupational therapist (community service)	0.57	0.76	0.86	0.53	0.24	0.67	1.59	0.67	0.3	0.61
Speech therapists and audiologists (grades 1–3)	0.67	0	1.69	0.75	1.35	1.61	2.09	0.64	0.76	1.07
Social worker	1.9	0	2.44	2.07	0.64	1.26	2.98	1.41	2.65	1.83
Professional nurse	117.9	0	74.82	81.74	97.97	87.8	78.45	78.56	55.23	80
Professional nurse specialty	26.27	0	27.58	37.49	31.82	22.57	16.9	17.71	27.89	27.23
Professional nurse (community service)	10.21	9	7.19	7.31	1.66	5.91	10.64	13.36	7.16	7.47

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