

Political Determinants of Mental Health in Africa: why it matters and the way forward

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Abstract

While global health discourse increasingly acknowledges the significance of social determinants of health, the pervasive impact of political structures, governance systems, and policy choices on mental health outcomes remains substantially under-examined, particularly within Africa. Existing literatures predominantly addresses individual risk factors, service delivery gaps, and social conditions, often neglecting how political decisions shape these realities. Political determinants, such as the enduring legacies of colonial violence, fragile state institutions, exclusionary and discriminatory laws, and chronically under-resourced health systems, are fundamental drivers of Africa's mental health burden. These factors determine exposure to harm, access to care, and the visibility of suffering. Addressing political determinants is not solely a clinical or public health issue; it is essential for achieving sustainable development, promoting social justice, reducing health inequities, and realizing universal health coverage across the continent.

Keywords: Political determinants, mental health, Africa, health equity, governance, universal health coverage, social justice

Introduction

Mental health conditions constitute a leading cause of disability worldwide, with the World Health Organization (WHO) estimating a 15% increase in the burden of mental disorders in Africa over the last decade [1]. Conventional epidemiological models often focus on biomedical and proximate psychosocial risk factors. However, this lens fails to capture the foundational role of the political environment. The political determinants of health are defined as the systematic processes of structuring relationships, distributing resources, and administering power, which ultimately manifest as health inequities [2]. In the African context, these determinants are not abstract; they are the lived realities of historical trauma, economic marginalisation, and political exclusion that directly sculpt the population's psychological landscape.

The Colonial Legacy and Epistemic Injustice

The contemporary mental health infrastructure and discourse in Africa are indelibly marked by

colonialism. Colonial psychiatry was primarily a tool of social control, pathologizing resistance and enforcing racist ideologies [3]. This history has bred a deep and enduring mistrust of formal mental health systems. Furthermore, it entrenched a form of epistemic injustice, systematically devaluing indigenous, community-based understandings of psychosocial well-being and healing practices [4]. Post-independence, many nations inherited legal frameworks, such as antiquated mental health acts, that emphasise custodial care over rights-based community rehabilitation, perpetuating stigma and human rights abuses [5]. The political failure to decolonise mental health policy and integrate validated indigenous knowledge systems represents an ongoing barrier to care-seeking and effective service delivery.

Conflict, Forced Displacement, and Chronic Insecurity

Africa bears a disproportionate burden of conflict

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and terrorist violence, from the Sahel to the Horn of Africa and the Great Lakes region. The mental health consequences are catastrophic. Exposure to violence, loss, and forced displacement are potent risk factors for depression, anxiety, post-traumatic stress disorder (PTSD), and profound, inter-generational grief [6]. Political decisions that fuel corruption, ethnic marginalisation, and state violence are direct etiological agents of this trauma. Moreover, chronic insecurity destroys social fabric, dismantles livelihoods, and overwhelms any fragile existing health services, creating a cyclical relationship between political instability and population-level psychological distress.

The Political Economy of Mental Health Neglect

Chronic underfunding of mental health necessitates an examination of the political economy shaping resource allocation. The neglect of mental health is not simply an oversight; rather, it stems from intentional political strategies employed by influential actors within systems of power and patronage. Domestic political elites face asymmetric incentives, as mental health services offer limited electoral returns compared to highly visible infrastructure projects. In clientelistic political systems common in Africa, where political survival depends on delivering material benefits to key constituencies, investment in mental health yields little political advantage [7].

Individuals with severe mental illness are often politically marginalized, lacking organized advocacy groups and concentrated voting power.

International financial institutions (IFIs), including the World Bank and IMF, exert considerable influence through loan conditionalities and technical guidance. While IFIs publicly commit to strengthening health systems, their fiscal consolidation programs often restrict public spending on non-communicable diseases and mental health [8]. Private sector actors similarly lack commercial incentives to invest in mental health in low-income African contexts, as markets for psychotropic medications remain limited and unprofitable.

Even when mental health budgets are allocated, rent-seeking behaviours frequently divert resources away from intended services. The Life Esidimeni tragedy in South Africa, where 144 psychiatric patients died after being transferred to unlicensed facilities, illustrates how political expediency and cost-cutting measures can lead to preventable deaths [9]. This case demonstrates that resource capture occurs not only through overt corruption but also through politically motivated austerity measures that disproportionately affect vulnerable populations. Furthermore, illicit financial flows and tax avoidance by multinational corporations deprive health services of significant funding [10]. Political decisions to prioritize debt servicing to international creditors over social sector investment further constrain fiscal space for health. These interacting political forces collectively shape mental health inequities across the continent (Fig. 1).



Figure 1: Political Determinants of Mental Health in Africa

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Economic Policy, Austerity, and Social Determinants

Macroeconomic policies, often dictated by international financial institutions or domestic elite interests, are profound political determinants. Structural adjustment programmes (SAPs) of the late 20th century decimated public health spending across the continent, crippling the development of mental health services [11]. The enduring legacy is a treatment gap exceeding 90% for severe mental disorders in many countries [1]. Furthermore, austerity measures, regressive taxation, and illicit financial flows limit state capacity to invest in the social determinants of mental health: quality education, social protection, food security, and decent work. Unemployment, especially among youth, and pervasive economic inequality are powerful drivers of hopelessness, anxiety, and substance misuse [12,13]. The substance use crisis among young people in countries like Sierra Leone exemplifies how economic marginalisation and limited opportunities translate directly into mental health and addiction challenges [13]. Politics that prioritise debt servicing over human capital investment directly fuel the mental health crisis.

Discrimination, Human Rights, and Exclusionary Laws

Political and legal frameworks that institutionalise discrimination have severe mental health repercussions.

Discriminatory laws against LGBTQ+ individuals, for example, are associated with significantly higher rates of depression, suicidality, and internalised stigma among sexual minorities [14]. Similarly, the political disenfranchisement and systemic neglect of people with disabilities, ethnic minorities, and refugees compound psychological distress. Gender-based violence, often inadequately addressed due to weak legal frameworks and patriarchal norms, is a major cause of trauma and mental ill-health among women and girls [15]. When the state, through action or inaction, sanctions discrimination, it becomes a direct determinant of poor mental health.

Governance and Health System Architecture

The absolute neglect of mental health within national health policies and budgets is a political choice. The WHO Mental Health Atlas consistently reveals that African region has the lowest per capita spending on mental health and the fewest mental health professionals globally [16]. Mental health remains siloed within centralised, tertiary institutions, failing to be integrated into primary healthcare, a policy failure of prioritisation. Political leadership that views mental health as a peripheral concern, rather than a core component of universal health coverage (UHC), ensures the perpetuation of this crisis. The lack of meaningful participation of people with lived experience in policy-making further entrenches this marginalisation. The diverse experiences of African countries illustrate how political determinants operate across legal, fiscal, and governance domains (Table 1).

Table 1: Summary of Country Case Examples and Political Determinants

Country	Political Determinant	Policy Intervention	Outcome/Status	Key Lesson
Ghana	Colonial-era legislation perpetuating human rights violations	Mental Health Act 2012: rights-based framework, community care mandate	Implementation challenged by resource constraints and limited oversight capacity	Legislative reform requires sustained political commitment and adequate funding
Ethiopia	Severe workforce shortage and geographic inaccessibility	mhGAP task-shifting to non-specialists in primary care	Expanded access but <1% health budget; vulnerable to donor dependency	Innovative models require domestic budgetary protection from donor fluctuations
South Africa	Chronic underfunding despite progressive policies; rent-seeking and corruption	Mental health policies on paper without implementation; cost-cutting transfers	Life Esidimeni tragedy (144 deaths); continued institutionalisation	Political will must translate to budgets and accountability mechanisms
Rwanda	Post-genocide mass psychological trauma; inadequate psychosocial infrastructure	Integration into reconciliation, justice, and poverty reduction frameworks	Highest mental health worker ratio in sub-Saharan Africa; ongoing challenges	Framing mental health as essential to national development mobilises resources
Kenya	Limited civil society space; weak advocacy influence; donor dependency	Civil society advocacy for Mental Health Amendment Bill; peer support programmes	Bill languishing in parliament; services remain donor-dependent	Civil society requires protected space, sustainable funding, and genuine inclusion

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The Imperative for a Political Solution

Ignoring these political determinants has grave consequences. It leads to ineffective interventions that treat symptoms while ignoring root causes. It perpetuates a massive economic burden through lost productivity, estimated to cost the global economy \$16 trillion by 2030, with Africa facing a disproportionate share due to its youthful population [17]. Crucially, poor mental health undermines every sustainable development goal (SDG), from poverty reduction to education, peace, and justice.

Addressing this requires a paradigm shift from a purely clinical to a political-economy approach:

Adopt a Rights-Based Framework: Governments must repeal discriminatory laws and align mental health legislation with the UN Convention on the Rights of Persons with Disabilities (CRPD), moving from coercion to supported decision-making [5]. Ghana provides an instructive example of progressive reform. The country's Mental Health Act of 2012 represents one of the most rights-based mental health legislations on the continent, explicitly prohibiting involuntary admission except under stringent safeguards and establishing a Mental Health Authority to protect patient rights [18]. The Act mandates community-based care, limits the use of restraints, and requires informed consent for treatment. However, implementation remains challenged by resource constraints and limited capacity for oversight, illustrating that legislative reform must be coupled with sustained political commitment and adequate funding. Conversely, many countries still operate under colonial-era mental health laws. For instance, several Anglophone African nations continue to use Mental Treatment Acts inherited from British colonial administration, which prioritise institutional confinement and grant broad powers for involuntary detention with minimal judicial oversight [19]. These antiquated frameworks perpetuate stigma, violate human rights, and deter individuals from seeking care.

Increase Political Commitment and Financing: Domestic health budgets must ring-fence funding for mental health, targeting integration into primary care and community-based services. This is a matter of political will. Ethiopia's

Mental Health Strategy demonstrates the potential of political commitment despite limited resources [20]. The country integrated mental health into its primary healthcare system through the Mental Health Gap Action Programme (mhGAP), training non-specialist health workers to deliver evidence-based interventions for priority mental disorders. This task-shifting approach, supported by government policy and international partnerships, has expanded access to mental health services in rural areas where psychiatric specialists are virtually absent. By 2014, a total of 244 health centers completed mhGAP training, and by 2020, 5,000 urban Health Extension Workers participated in refresher training which includes mental health content [21]. However, the sustainability of these gains remains precarious. Mental health receives less than 1% of the national health budget, and services remain heavily dependent on donor funding, rendering them vulnerable to external funding fluctuations [16]. In contrast, South Africa, despite being an upper-middle-income country with greater resources, has struggled with political prioritisation. Although the country has progressive mental health policies on paper, chronic underfunding and poor implementation have resulted in continued institutionalisation, human rights violations in psychiatric facilities, and a severe shortage of community-based services [22]. These contrasting cases underscore that while innovative models exist, sustainable progress requires not just initial political commitment but ongoing budgetary allocation, accountability mechanisms, and protection from competing political priorities.

Mainstream Mental Health in All Policies: Mental health impact assessments should be required for economic, social, and security policies. Building social safety nets, investing in education, and ensuring peace and security are mental health policies. Rwanda offers a compelling example of integrating mental health into broader policy frameworks following the 1994 genocide [23]. The government recognised that national reconciliation and development were impossible without addressing the massive psychological trauma affecting the population. Mental health was incorporated into community-level justice processes [24], national unity and reconciliation programmes, and poverty reduction strategies. The Ministry of Health established community-based sociotherapy programmes, integrating trauma healing into village-

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level governance structures. By framing mental health not as a standalone health issue but as integral to social cohesion, economic productivity, and national security, Rwanda mobilised resources and political support that would have been unavailable through a purely clinical approach. Today, the country has one of the highest ratios of mental health workers to population in sub-Saharan Africa [25]. Nevertheless, challenges persist, demonstrating that political leadership can reframe mental health as central to national development, but this requires deliberate policy architecture that embeds mental well-being across government sectors, not just health ministries.

Support Civil Society and Lived Experience Leadership: Grassroots organisations and advocacy groups led by those with lived experience must be empowered to hold governments accountable and shape responsive services. Kenya's mental health advocacy landscape illustrates both the potential and limitations of civil society engagement [26]. Organisations such as BasicNeeds Kenya and the Kenya National Association for the Mentally Handicapped have mobilised people with lived experience, challenging stigma and advocating for policy reform. These groups played crucial roles in pushing for the Mental Health (Amendment) Bill 2014, which sought to replace colonial-era legislation with rights-based provisions. Civil society-led community support groups have also filled gaps in formal services, providing peer support and livelihood programmes that address both mental health and socioeconomic determinants. However, the political space for mental health advocacy in Kenya remains constrained by limited funding, weak legal protection for advocacy organisations, and government reluctance to genuinely include civil society in policy formulation [27]. The Mental Health Bill has languished in parliament for years, reflecting insufficient political will despite civil society pressure. Moreover, most mental health advocacy organisations depend heavily on international donors, making them vulnerable to funding shifts and raising questions about sustainability and local ownership.

Foster Regional Collaboration: African Union bodies like the Africa CDC must prioritise mental health as part of health security agendas, sharing best practices and advocating for continental

commitments. The African Union's Agenda 2063 and the Catalytic Framework to End AIDS, TB and Eliminate Malaria provide precedents for high-level continental commitment to health priorities [28]. However, mental health has received minimal attention in pan-African health governance structures compared to communicable diseases. The COVID-19 pandemic revealed both the need and potential for regional mental health coordination, as the Africa CDC recognised mental health and psychosocial support as critical components of pandemic response, issuing guidance documents and facilitating knowledge exchange across member states [29]. This represents a nascent recognition of mental health as a health security issue. The East African Community has made modest progress, with member states initiating discussions on harmonising mental health policies and potentially establishing regional standards for mental health service delivery, though concrete implementation remains limited [30]. Regional economic communities could play vital roles in setting minimum standards for mental health spending, sharing successful policy innovations like Ghana's Mental Health Act or Ethiopia's task-shifting models, and creating accountability mechanisms for member states. South-South cooperation, such as exchanges between African countries that have achieved mental health integration and those beginning the process, could be more culturally appropriate and politically acceptable than North-South technical assistance that carries colonial overtones. For regional collaboration to meaningfully advance mental health, it requires deliberate advocacy to elevate mental health on political agendas, dedicated funding for regional mental health programmes, and the establishment of accountability frameworks that create peer pressure among member states to improve mental health governance.

Conclusion

The mental health status of populations across Africa reflects the continent's underlying political realities. Widespread depression, anxiety, and trauma are not solely medical issues; they also indicate the consequences of historical injustice, ineffective governance, and inequitable economic systems. Political economy analysis reveals that neglect of mental health often results from calculated decisions by political elites responding to asymmetric incentives, international financial institutions emphasizing fiscal consolidation, and rent-seeking

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actors appropriating limited resources. Investment in mental health, therefore, constitutes an investment in social cohesion, human capital, and the development of resilient democracies.

Progress requires the identification and support of policy entrepreneurs who can effectively navigate bureaucratic and political obstacles, as demonstrated in Ghana and Ethiopia. It is also necessary to strategically utilize windows of opportunity, such as public health crises like COVID-19, constitutional reforms, and post-conflict transitions, to integrate mental health into broader political agendas. Robust accountability mechanisms are essential, including incorporating mental health metrics into African Union peer-review processes, linking performance to Sustainable Development Goals (SDG) reporting, and using civil society scorecards to monitor specific, measurable commitments. These strategies should extend beyond budget allocations to assess actual service availability and meaningful quality outcomes for individuals with lived experience.

Researchers should expand interdisciplinary collaboration among political science, economics, and psychiatry. Health professionals are also called to advocate for governance reform. Ultimately, the pursuit of mental well-being for all in Africa extends beyond a health objective; it is a fundamentally political endeavor vital to the continent's equitable and prosperous future.

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Authors Contribution

Adeyeye P. and Ugwu R. contributed equally to all aspects of the article, including the conceptualization, drafting, and critical revision.

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