AFRICA HEALTH ORGANISATION

AHO PLAN OF ACTION ON MENTAL HEALTH

PUTTING MENTAL HEALTH ON THE CONTINENTAL MAP OF AFRICA

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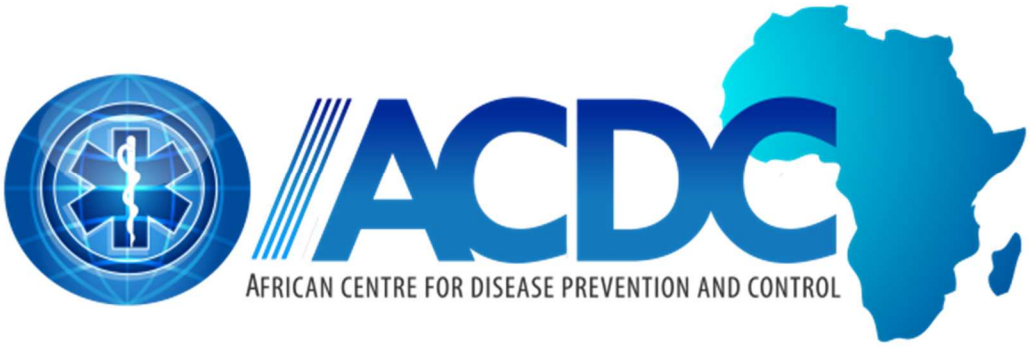
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Africa Mental Health Service
SUPPORTING MENTAL HEALTH


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GRACIANO MASAUSO
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Preface

Mental disorders increase risk for other diseases and contribute to unintentional and intentional injury. Furthermore, disease, whether communicable or noncommunicable, increases risk for mental disorders. Depression, for example, is a frequent co-morbid condition that complicates the search for help and adherence to treatment, and affects the prognosis. There is evidence that depression predisposes to heart attack and diabetes, which in turn increases the likelihood of suffering from depression. Many risk factors, such as low socioeconomic status, alcohol use and stress are common to mental disorders and to other noncommunicable diseases. Coordinated care and treatment of mental disorders and other physical conditions can improve outcomes for both, which is very important, especially at the primary health care level, where integrated care models can be developed.

Mental disorders and psychoactive substance-related disorders are highly prevalent throughout the world and are major contributors to morbidity, disability, and premature mortality. However, the resources allocated by countries to tackle this burden are insufficient, are inequitably distributed, and, at times, inefficiently used. Together, this has led to a treatment gap that, in many countries, is more than 70%. The stigma, social exclusion, and discrimination that occur around people with mental disorders compound the situation.

The organization of mental health services is not uniform in Africa. Some countries have implemented innovative community-based solutions. Many others still have a highly centralized system, where the response to problems of people with mental disorders and alcohol or other substance disorders is concentrated in psychiatric hospitals, with limited or no development of health services at the primary or secondary level. In some countries, 86.6% of psychiatric beds are in psychiatric hospitals, 10.6% are in general hospitals, and only 2.7% are in community residences.

The Plan of Action reflects the experience gained and expresses the commitment of the governments. It sets a period of six years for its implementation. The Plan is based on an overall view; however, marked differences persist among the countries and even within an individual country. For this reason, there should be flexibility in its implementation, in particular to adapt the proposed results and indicators as necessary and adjust them to the specifics of the countries and to cultural contexts. Furthermore, in federated states, the shared jurisdictional responsibility between national and subnational governments should be taken into account.

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Introduction

1. Mental disorders and psychoactive substance-related disorders are highly prevalent throughout the world and are major contributors to morbidity, disability, and premature mortality. However, the resources allocated by countries to tackle this burden are insufficient, are inequitably distributed, and, at times, inefficiently used. Together, this has led to a treatment gap that, in many countries, is more than 70%. The stigma, social exclusion, and discrimination that occur around people with mental disorders compound the situation.

2. *There is no health without mental health*. This message clearly expresses the need for a comprehensive approach to health and emphasizes the links between physical and psychosocial aspects of the health-disease process. Mental disorders increase risk for other diseases and contribute to unintentional and intentional injury. Furthermore, disease, whether communicable or noncommunicable, increases risk for mental disorders. Depression, for example, is a frequent co-morbid condition that complicates the search for help and adherence to treatment, and affects the prognosis. There is evidence that depression predisposes to heart attack and diabetes, which in turn increases the likelihood of suffering from depression. Many risk factors, such as low socioeconomic status, alcohol use and stress are common to mental disorders and to other noncommunicable diseases. Coordinated care and treatment of mental disorders and other physical conditions can improve outcomes for both, which is very important, especially at the primary health care level, where integrated care models can be developed.

3. Africa Health Organisation (AHO) conceptualises mental health as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

4. In 2016, the AHO Health Congress approved the Comprehensive mental health action plan 2020-2030. In view of the foregoing, at the regional level, it has been decided to review the Plan of Action on Mental Health, in order to update it and align it with the AHO Strategic Plan and with the Comprehensive mental health action plan.

Background

5. There is need to underscored that psychiatric-hospital cantered care had to be replaced with decentralized, participatory, integrated, continuing, preventive, and community-based services, respecting the exercise of human rights.

6. AHO addressed the subject of mental health and issued resolutions that urged governments to include mental health among their priorities.

7. In recent years, the following extremely important programming documents have been observed:

a) Global strategy to reduce the harmful use of alcohol, WHO, 2011;

b) Political declaration on non-communicable diseases (NCDs), UN, 2011;

Comprehensive global monitoring framework, WHO, 2013;
c) Strategic Plan 2020-2030, AHO.
d) Meeting of Users of Mental Health Services and their Families, sponsored by AHO, 2016.

Situation Analysis

8. A recent review of several epidemiological studies done in Africa found 12-month prevalences for any mental disorder from 18.7% to 24.2%. Median 12-month prevalence rates in the adult population for some disorders are: nonaffective psychosis, 1.0%; major depression, 5.2%; and alcohol abuse/dependence, 4.6%.

9. In terms of burden and prevalence, depression continues to be the leading mental disorder, and is twice as frequent in women as in men. From 10% to 15% of women in industrialized countries and from 20% to 40% of women in developing countries suffer from depression during pregnancy or the postpartum period.

10. Disorders due to the use of alcohol and other psychoactive substances, such as illegal drugs and medically prescribed psychotropics, are a growing epidemiological problem with great social impact; however the treatment gap is very wide *(18, 26)* and adequate services are not available to face this situation.

11. The Region is experiencing a demographic transition, which is posing a challenge that mental health services must address. Mental and neurological disorders in the elderly, such as Alzheimer's disease, other dementias, and depression, contribute significantly to the burden of noncommunicable diseases. Projections indicate that the number of people with dementia will double every 20 years.

12. Availability of data on mental health services has increased understanding of the magnitude of the treatment gap. Among adults with severe and moderate affective, anxiety, and substance use disorders, the median treatment gap is 73.5% for some areas and 77.9% for others. The treatment gap is 56.9% for schizophrenia, 73.9% for depression, and 85.1% for alcohol.

13. In the Africa, 65,000 people die from suicide every year. The age-adjusted suicide rate, per 100,000 population, is 7.3 (11.5 for men and 3.0 for women). Suicide is the third leading cause of death in the group aged 20 to 24 years, and fourth in the groups aged 10 to 19 and 25 to 44. The most commonly used methods are suffocation, firearms, and poisoning (using pesticides, in particular). Mortality from suicide continues to be higher in men than in women (male-female ratio of 3.8); however, women report more suicide attempts.

14. In Africa, violence is an important social-health problem. Violence against women, which affects one out of every three women, gives rise to multiple health consequences, ranging from depression to death, including suicide. Violence against children creates intergenerational cycles of violence against women and girls, leading to the same results. Physical punishment of children is frequent in many parts of Africa. For example, according to national surveys conducted in

some countries, more than one third of women, and at least half of men reported that they had been hit during childhood.

Policies, Plans, Legislation, and Organization of Services

15. According to this study, only six countries do not have mental health policies and plans. In contrast, only eight countries do have specific up-to-date mental health laws. With respect to the financial situation, 73% of countries assign from 1% to 5% of the health budget to mental health. Furthermore, of the 27 countries with psychiatric hospitals, 20 allocate more than 50% of the mental health budget to these institutions; and 14 of those 20 assign over 80%.

16. The organization of mental health services is not uniform in Africa. Some countries have implemented innovative community-based solutions. Many others still have a highly centralized system, where the response to problems of people with mental disorders and alcohol or other substance disorders is concentrated in psychiatric hospitals, with limited or no development of health services at the primary or secondary level. In some countries, 86.6% of psychiatric beds are in psychiatric hospitals, 10.6% are in general hospitals, and only 2.7% are in community residences.

17. Primary care has played a limited role in the mental health area, although the situation is gradually changing.

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18. From the standpoint of human resources, the disparity among countries is great. It is observed that, where the psychiatric hospital is at the base of the system, most of the available resources are found concentrated there. In some countries, there is a median of 2.1 psychiatrists, 6.0 nurses, and 4.2 psychologists per 100,000 population.

19. AHO revealed the paucity of information on mental health. In many countries, data are difficult to obtain and sometimes non-existent, and health information systems do not include mental health indicators.

20. Consultation show that many countries have achieved substantial progress; nevertheless, there is still a long way to go. Noteworthy progress has been made, including the following: *a)* several countries have continued with sustainable processes to reduce the number of psychiatric hospital beds, through alternatives in decentralized outpatient services; *b)* in the last three years, work has been done to integrate a mental health component into primary health care; and *c)* some countries have drafted and passed mental health laws that incorporate international human rights instruments.

21. On the other hand, the treatment gap is the great challenge we are facing today. Tearing down barriers to access to services as part of a universal coverage policy is the key, and this includes integration of mental health into general health services.

Plan of Action (2020-2030)

22. The Plan of Action reflects the experience gained and expresses the commitment of the governments. It sets a period of six years for its implementation. The Plan is based on an overall view; however, marked differences persist among the countries and even within an individual country. For this reason, there should be flexibility in its implementation, in particular to adapt the proposed results and indicators as necessary and adjust them to the specifics of the countries and to cultural contexts. Furthermore, in federated states, the shared jurisdictional responsibility between national and subnational governments should be taken into account.

23. *Vision*: Africa in which mental health is valued, promoted, and protected, mental and substance-related disorders are prevented, and persons with these disorders are able to exercise their human rights and to access both health and social care that is timely and high-quality, to attain the highest possible level of health and to contribute to the well-being of families and communities.

24. *Goal:* Promote mental well-being, prevent mental and substance-related disorders, offer care, enhance rehabilitation, emphasize recovery, and promote the human rights of persons with mental and substance-related disorders, to reduce morbidity, disability, and mortality.

Strategic Lines of Action

25. This document is aligned with the AHO Strategic Plan 2020-2030 and the Comprehensive mental health action plan, with special attention to results, indicators, and targets that are matching. The Plan contains the following strategic lines of action to guide governments in accordance with their national contexts and priorities:

a) Develop and implement policies, plans, and laws in the field of mental health and mental health promotion, to achieve and appropriate and effective governance.

b) Improve the response capacity of systems and services for mental health and for the care of psychoactive substance-related disorders, to provide comprehensive, quality care in community-based settings.

c) Prepare and implement programs for promotion and prevention in the area of systems and services for mental health and for the care of alcohol- and substance related disorders, with particular attention to the life course.

d) Strengthen information systems, scientific evidence, and research.

26. The Plan of Action is based on four cross-cutting themes, according to the provisions of the AHO Strategic Plan: gender, equity, ethnicity, and human rights. Environmental, biological, socio-economic, cultural, and health system-related dimensions are also considered. Gender inequalities—in interaction with other social determinants of health—explain differences in exposure to risks and in mental health outcomes for women and men. From this perspective, when putting mental health care into practice, it should take into account gender-based living conditions and specific needs.

27. The ethnicity perspective involves an intercultural approach in mental health services. It is necessary to have personnel that know and respect cultural and religious knowledge and beliefs, as well as the language of different people, and integrates these elements into their work. The exercise of human rights is fundamental for responding to the burden of mental illness within a

framework of respect for human dignity. A set of relevant international instruments on human rights is currently available.

Strategic Line of Action 1: Develop and implement policies, plans, and laws in the field of mental health and mental health promotion, to achieve appropriate and effective governance.

28. The design and implementation of national policies, plans, and laws in the field of mental health and mental health promotion, based on scientific data and in accordance with international human rights instruments, is a challenge that requires a joint effort by the public sector with other key entities. Leadership and commitment from governments and health workers are essential to develop comprehensive mental health plans integrated into public policies and to facilitate the organization of a community-based and evidence-based service model that promotes and protects the human rights of persons with mental and substance-related disorders and their families.

29. Civil society plays a key role in the preparation and implementation of plans and laws, in particular through associations of users of mental health services and their families, peer support groups, social support groups, community integration and participation, and the promotion of effective and appropriate services. In the first year of implementation of the Plan a baseline will be established to measure progress of the civil society role.

30. Legislation on mental health and on human rights provides a legal framework for promoting and protecting the human rights of people with mental and substance-related disorders . When mental health is addressed both in independent legislation (law) and when it is integrated into other laws on health and capacity, these should codify the principles, values, and basic objectives of international human rights instruments, and be consistent with the best international technical standards.

31. An essential problem is the shortage and inequitable distribution of human and financial resources devoted to mental health, especially considering the burden that mental and substance-related disorders represent. Also, in many cases, expenditures are structured so that a high proportion of the mental health budget is allocated to the large psychiatric hospitals (see situation analysis). The preceding data illustrate the need not only to increase the budget in absolute terms, but also to consider redirecting resources from psychiatric hospitals to ambulatory and community-based systems. Expenditures should be coherently aimed at meeting the population's mental health needs.

Objective 1.1. Develop and implement national policies or plans for mental health and mental health promotion that are aligned with regional and global mental health plans.*

Indicator:

1.1.1 Number of countries that have a national mental health policy or plan in line with regional and global mental health plans.
Baseline (2020): 22. Target (2030): 30.

Objective 1.2. Draft and implement national mental health laws consistent with international human rights instruments.*
Indicator:
1.2.1 Number of countries that have national mental health laws consistent with international human rights instruments.
Baseline (2020): 8.** Target (2030): 18.

Strategic Line of Action 2: Improve the response capacity of systems and services for mental health and the care of psychoactive substance-related disorders, to provide comprehensive, quality care in community-based settings.

32. A community mental health model is grounded on basic principles adopted and adapted by each country to organize service delivery. Its cornerstones include decentralization, inclusion of a mental health component in primary health care and in general hospitals, the existence of a service network, social participation, inter-sectoral coordination, and a human rights approach. It also implies the delivery of services that are culturally appropriate, equitable, and free from discrimination based on gender, race or ethnic group, sexual orientation, social class, or other conditions.

33. An unfinished task in the Region is the restructuring of mental health services. Development of a community model involves planning new services and alternatives that offer comprehensive and continuous care that make it possible to replace psychiatric hospitals in a progressive and appropriate manner, while maintaining the availability of temporary hospital care for persons with mental or substance-related disorders who need such care. Since, in many countries, psychiatric hospitals still consume a large part of the resources dedicated to mental health, a recommended strategy is to use these resources to establish specialized services in general hospitals and in the community.

34. In its action plan, AHO defines recovery as “gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self.
Recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery - hope, healing, empowerment and connection - and external conditions that facilitate recovery -implementation of human rights, a positive culture of healing, and recovery-oriented services.

35. Community-based mental health services should be comprehensive and include psychosocial rehabilitation, allowing the social reintegration of persons with mental disorders. Also, these services should base their approach on recovery, with emphasis on the support that people with mental disorders need to reach their own aspirations and goals. Among other tasks, these services should be “listening and responding to individuals' understanding of their condition and what

helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise. In addition, a multi-sectoral approach is required whereby services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment (including return-to-work programs), housing and educational opportunities, and participation in community activities, programs and meaningful activities."

36. An integrated approach to mental disorders that combines psychosocial and pharmacological interventions is the most effective. Availability of essential psychotropic drugs in community outpatient services and in primary health care is crucial.

37. Systematic evaluation of mental health services guarantees that quality care is provided and that the human rights of service users and their family members are respected. The AHO *Quality Rights* project offers instruments and a methodology, which have begun to be adapted and implemented.

38. Services should be responsive to the needs of vulnerable groups, especially those who are socioeconomically disadvantaged; the homeless mentally ill; people living with HIV/AIDS; women and children who are victims of violence; survivors of violence; indigenous peoples; migrants and displaced persons; persons deprived of liberty; and minority groups within the national context. The term "vulnerable group" is used in this Plan to refer to individuals or a set of people that have acquired that vulnerability due to exposure to specific situations and conditions in their environment (not, of course, intrinsic weaknesses or lack of capacity). Each country should apply the term "vulnerable group" in accordance with its own context and characteristics.

39. Exposure to adverse life events, such as natural or man-made disasters, armed conflicts, civil unrest, continuing domestic violence, and forced migration or displacement, has physical and mental health consequences. Therefore, availability of mental health services and psychosocial support should be assured when planning the response by the health sector and other sectors.

40. Having the right number and equitable distribution of appropriately skilled mental health workers is central to the expansion of services. Vocational training (college) and continuing education (graduate level) should reflect the policies for the integration of mental health into general health services, including primary health care. Specialized professionals should facilitate the training, support, and supervision of non-specialized personnel; for example, so that they can identify people with mental health problems and care for them or refer them to a more appropriate service, if available. Supporting and training family members and caregivers of people with mental disorders will also contribute to increasing the response capacity of mental health services.

41. When planning the expansion of mental health services, it is essential to ensure equitable access to comprehensive and efficient care that enables promotion, prevention, care, rehabilitation, and social reintegration. To this end, efforts to study and maximize the use of

technology (mobile telephones, video links, and Internet) should be undertaken, to guarantee access to mental health services in remote and neglected communities.

42. Increasing and decentralizing mental health services make it possible to gradually reduce the number of psychiatric hospital beds, which basically offer custodial care services. It is essential to set up specialized services in the community (outpatient clinics and general hospitals). The integration of a mental health component into primary health care and other health care settings (e.g., emergency departments, criminal justice system, school health clinics) is essential for development of equitable service delivery, in addition to being a crucial strategy for bridging the mental disorders treatment gap.

Objective 2.1. Increase outpatient service coverage for mental health.

Indicator:
2.1.1 Number of countries that have increased the rate of persons seen in outpatient mental health facilities above the regional average (975/100,000 population).
Baseline (2020): 19.++ Target (2030): 30.

Objective 2.2. Reduce role of psychiatric hospitals.

Indicator:
2.2.1 Number of countries where psychiatric hospitals have reduced the number of beds by at least 15%.
Baseline (2020): 0. Target (2030): 10.

Objective 2.3. Integrate mental health component into primary care.

Indicator:
2.3.1 Number of countries that have integrated a mental health component into primary care.
Baseline (2020): 15.+++ Target (2030):.

Strategic Line of Action 3: Prepare and implement promotion and prevention programs in the area of systems and services for mental health and for the care of alcohol- and substance-related disorders, with particular attention to the life course.

43. The role of other sectors is crucial in the area of promotion and prevention in mental health systems and services, because mental health and substance-related problems are influenced by social and economic determinants, including, for example, income level, employment status, education level, family cohesion, discrimination, violations of human rights, and exposure to adverse life events, including sexual violence, child abuse, and neglect.

44. The early stages of life present an important opportunity to work on promotion and prevention, as up to 50% of mental disorders in adults begin before the age of 14 years. Opportunities also exist for preventive intervention with the elderly to improve quality of life, facilitate social integration, and reduce or prevent disability.

45. Interventions to promote mental health and prevent mental disorders should include support for antidiscrimination laws and regulations, and information campaigns against stigmatization and human rights violations.

46. It is important for promotion and prevention programs to concentrate on evidence-based interventions that are appropriate to the context in which they are used.
Programs can include these actions, among others: the nurturing of core individual attributes in the formative stages of life, early identification and treatment of emotional or behavioural problems in childhood and adolescence, promotion of healthy living conditions, strengthening of community protection networks that tackle violence, and social protection for the poor.

47. Interventions to prevent suicide include reducing access to lethal means (in particular, firearms, bridges without barriers, pesticides, and medicines or drugs), responsible reporting by the media, and early recognition and treatment of mental disorders such as depression. It is essential to identify people at risk, monitor persons with suicidal ideation and previous suicide attempts, and provide immediate care to those who attempt suicide.

48. Based on this study of trends, it is predicted that mortality from suicide will remain stable, even though many countries will improve their registries and will carry out programs for the prevention of suicidal behaviour.

Objective 3.1. Implement mental health promotion and prevention programs.

Indicator:
3.1.1 Number of countries with operational multi-sectoral mental health promotion and prevention programs.

Baseline (2013): 20.§ Target (2020): 25.

Objective 3.2. Implement mental of suicide prevention programs.

Indicator:
3.2.1 Annual number of suicide deaths per 100,000 populations.
No increase in the regional suicide rate by 2030 compared to 2020.
Baseline: 7.3/100,000 population.

Indicator:
3.2.2 Number of countries that develop and implement national suicide prevention programs.
Baseline (2020): 6.♦ Target (2030): 20.

Strategic Line of Action 4: Strengthen information systems, scientific evidence, and research.

49. Health information systems should regularly collect and report data on mental health service delivery, which should be broken down, at a minimum, by gender, age, race or ethnic group, and diagnosis, as well as by sexual orientation (where possible).
These data should be used routinely for evaluation and to report to authorities, and as a basis for improvement and expansion of services. The basic set of indicators suggested in the AHO Plan of Action will be reviewed, for its adaptation and gradual implementation.

50. Most of the available information comes from psychiatric hospitals, and refers to number of beds and admissions, according to sex, age, and diagnoses, with very little information on other parameters, such as involuntary admissions. Information from outpatient services is more varied; occasionally, the number of contacts is reported, but there is almost never a case registry.

51. Only some countries have existing scientific research and produce data. To provide scientific evidence for interventions for the promotion, prevention, and treatment of mental and substance-related disorders, research should encompass a range of activities, including discovery, evaluation, treatment, and clinical testing, as well as service delivery, taking national priorities into account.

Objective 4.1. Strengthen information systems by integrating a basic set of mental health indicators that are systematically compiled and reported annually.
Indicator:
4.1.1 Number of countries with a basic set of agreed upon mental health indicators, systematically compiled and reported annually.
Baseline (2020): 21.• Target (2030): 30.

Monitoring, Analysis, and Evaluation

52. This action plan contributes to achievement of the goals for Category 2 in the AHO Strategic Plan. Monitoring and evaluation of this Plan will be aligned with the Organisation's results-based management framework and its performance evaluation processes. Progress reports will be prepared based on information available at the end of each biennium. Mid-term and final evaluations of the Plan will be done to determine the strengths and weaknesses of its overall implementation, causal factors of the successes and failures, and future actions.

53. The sources for the necessary information are: *a)* AHO mortality database; *b)* country reports updated every five years; *c)* other country reports related to this plan's indicators, requested from Ministries of Health; *d)* reports from the Mental Health and Substance Use Unit; and *e)* compilation of the research.

Financial Implications

54. It is estimated that the cost of implementation of the *Plan* for the 10-year period (2020-2030) will be USD213,880,080.00. This primarily for operating expenses for technical cooperation with the countries and for temporary contracting necessary for expert support in specific activities. It will be important to forge partnerships and identify donors who support the plan. Similarly, it is expected that the countries will prioritise the issue and allocate resources to improve their community-based mental health programs and services. Cooperation and experience sharing among countries will be important, for which it will be necessary to mobilize financial resources.

Summary

55. Recognizing that there is a high prevalence of mental and substance use disorders in the world and that this is a major contributor to morbidity, disability, and premature mortality, and that, in addition, there is a wide treatment gap;

56. Understanding that there is no health without mental health, conceptualized not only as the absence of disease, but as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"

57. Recalling key international human rights instruments, such as the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities

58. To summarise, the points of action are to:

a) include mental health and mental health promotion as a priority within national health policies, in order to ensure the implementation of mental health plans that consider the deficit and unequal distribution of resources in some countries;

b) strengthen, develop, review and, if necessary, reform country legal frameworks and their implementation, in order to protect the human rights of people with mental disorders;
c) support the involvement of civil society, and in particular user and family member associations, in the planning and implementation of activities to promote and protect the mental health of the population;

d) promote universal and equitable access to comprehensive, community-based mental health care for the entire population, through strengthening the response capacity of mental health systems and services within the framework of integrated service networks with particular emphasis on reducing the existing treatment gap;

e) continue efforts to shift from a psychiatric-hospital centered model to a community-based model that integrates a mental health component into primary health care and general hospitals, and that establishes decentralized mental health services close to where people live;

f) ensure an appropriate response by mental health services to the particular characteristics of vulnerable or special-needs groups;

g) ensure delivery of mental health services and psychosocial support in emergencies and disasters;

h) consider the strengthening of human resources in the field of mental health development as a key component in the improvement of the response capacity of services and in particular primary care, for which regular training programs are essential;

i) foster inter-sectoral initiatives to promote mental health and prevent mental disorders, with particular attention to the life course and on addressing stigma and discrimination directed at people with mental disorders;

j) undertake specific suicide prevention interventions that include improvement of information and surveillance systems;

k) bridge the existing mental health information gap through improvements in the production, analysis, and use of information, as well as through research;

l) strengthen multi-sectoral governmental partnerships, and partnerships with nongovernmental organizations, academic institutions, and other key social actors.

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