Decision-makers, donors and data: factors influencing the development of mental health and psychosocial policy in the Solomon Islands

Anthony B Zwi,1* Ilse Blignault,1 Anne W Bunde-Birouste,1 Jan E Ritchie1 and Derrick M Silove2

1School of Public Health and Community Medicine, The University of New South Wales, Sydney, NSW 2052, Australia and 2School of Psychiatry, The University of New South Wales, Sydney, NSW 2052, Australia.

*Corresponding author. School of Public Health and Community Medicine, The University of New South Wales, Sydney, NSW 2052, Australia. Tel: +61 2 9385 2445. Fax: +61 2 9385 1036. E-mail: a.zwi@unsw.edu.au

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Mental disorders and psychosocial problems are common, and present a significant public health burden globally. Increasingly, attention has been devoted to these issues in the aftermath of violent conflict. The Solomon Islands, a small Pacific island nation, has in recent years experienced periods of internal conflict. This article examines how policy decisions regarding mental health and wellbeing were incorporated into the national agenda in the years which followed.

The study reveals the policy shifts, contextual influences and players responsible. The Solomon Islands’ experience reflects incremental change, built upon long-standing but modest concern with mental health and social welfare issues, reinforced by advocacy from the small mental health team. Armed conflict and ethnic tensions from 1998 to 2003 promoted wider recognition of unmet mental health needs and psychosocial problems. Additional impetus was garnered through the positioning of key health leaders, some of whom were trained in public health. Working together, with an understanding of culture and politics, and drawing on external support, they drove the agenda. Contextual factors, notably further violence and the ongoing risk of instability, a growing youth population, and emerging international and local evidence, also played a part.

Keywords Mental health policy, policy analysis, Solomon Islands, post-conflict, agenda setting

KEY MESSAGES

- There is increased attention to mental health and psychosocial wellbeing in countries affected by, and/or emerging from, conflict.
- Policy shifts in the Solomon Islands reflect incremental change, built upon established concern with mental health issues, reinforced by advocacy on the part of local and international key players, external support and the broader post-conflict context.
- Policy change has been driven by multiple factors including: socio-cultural issues; bureaucratic motivation; research and evidence; external factors including international aid; and political, security and economic concerns.
- In addition to the oft-cited three ‘p’s of agenda-setting—problem, politics and policy—we add three ‘d’s which underpin the process in developing countries: decision-makers, donors and data. Together these advance policy agendas.
Introduction

Once known as the ‘Happy Isles’, the small Western Pacific nation of the Solomon Islands (SI) experienced a number of episodic internal conflicts, transforming it into the ‘Happy Isles in Crisis’ (Moore 2004). In May 2006, the Prime Minister, Manasseh Sogavare, presented the government’s vision for the future. Among the policy proposals was the simple statement: ‘government will strengthen mental health services and take measures to extend such services to vulnerable groups’ (Solomon Islands Prime Minister’s Office 2006: 41).

This research commenced in 2006 and explored systematically how policy decisions regarding mental health and wellbeing, over the previous 10 years, were made and incorporated into the national agenda.

Mental disorders and psychosocial problems1 present a significant global public health burden and are attracting increasing attention (Patel 2008). They are stigmatizing, posing stress on the community and services; securing equitable and effective treatment and support is an ongoing human rights challenge (WHO 2001; Psychosocial Working Group 2003a, 2003b, 2004; Prince et al. 2007).

Attention has been devoted to mental health and wellbeing in the aftermath of violent conflict, reflecting awareness of increased rates of psychosocial problems and mental disorders accompanying such crises (Baingana et al. 2005; Silove and Steel 2006), together with a perception that additional support and services are required for those who have experienced ‘trauma’. Intensified interest of donors and international non-governmental organizations (NGOs) is often present, albeit typically for the short term (Stockwell et al. 2005; De Vries and Klazinga 2006). Powerful international actors (bilateral donors, United Nations agencies and NGOs) influence the direction of policy and practice; their access to funds and analytic insights places them in a position of power relative to national government and local professionals (Das 2009). Thus, while international engagement and funding opens opportunities to rethink, reshape and redirect activities, there remains a risk that poorly designed policies and services may be introduced and may undermine local capacity, expertise, resilience and sustainability.

Debate concerning good development practice in fragile states and in their health sectors is ongoing and intensifying (see Kumar 1997; Paris 2004; Zwi and Grove 2006; Health and Fragile States Network 2009). Approaches differ depending on whether one is dealing with a state which is weak, but committed to addressing the needs of its citizens, as in SI, or whether the state itself is repressive, violent and undermines human rights, thus making it a major part of the problem.

Background: Solomon Islands and objectives of the project

Located in the Pacific Ocean to the east of Papua New Guinea (PNG), SI comprise nearly 1000 islands covering a land area of 30400 km² and a sea area of about 1.5 million km². The ‘backbone’ comprises a double chain of six major islands: Choiseul, New Georgia, Isabel, Malaita, Makira and Guadalcanal, on which the capital, Honiara, is located. The population in 2007 was estimated at 567,800 (Central Intelligence Agency 2007). Over 83% of the population live in rural areas where subsistence agriculture, fishing and food gathering are the main sources of income (Solomon Islands Government Statistics Office 1999).

At independence from Britain in 1978, SI was a low-income, aid-dependent country with poor health and welfare indicators; it still has many of these features. Limited education, especially for rural communities and women, has been characteristic (UNDP 2006). In 2008, the Human Development Index placed SI 134 out of 179 countries (UNDP 2008). GDP per capita (US$ PPP) was $1586 in 2006 (UNDP 2008). The country is 96% Christian (Solomon Islands Government Statistics Office 1999). Aid dependence is high, comprising 70.5% of Gross National Income in 2005, mostly bilateral, with Australia the largest donor (OECD 2007). The recent global economic crisis may have exacerbated socio-economic and political vulnerabilities.

The country experienced widespread armed conflict, known locally as the ‘tensions’, from 1998 to 2003 (UNDP 2004). Contributory factors included competition for limited land resources around Honiara and cultural differences between ethnic populations (especially between, but not limited to, people from Guadalcanal and Malaita). After signing the Townsville Peace Agreement in October 2000, hostilities continued and escalated in southern Guadalcanal. The conflict is estimated to have resulted in 150–200 deaths, approximately 450 gun-related injuries, and more than 35,000 people becoming displaced (UNIFEM 2005).

In 2003, Australia and a range of other countries were ‘invited’ by the SI government to establish the Regional Assistance Mission to the Solomon Islands (RAMSI) to defuse the situation. RAMSI sought to strengthen governance, stabilize government finances and operations, revitalize the courts, rebuild the prison systems and strengthen the police service. According to the Australian Government, it also sought to build capacity and create the conditions necessary for a return to stability, peace and a functional, growing economy (Commonwealth of Australia 2003). In the health sector, Australian engagement was focused through the Health Institutional Strengthening Project (HISP).

This research sought to examine how, and by whom, psychosocial and mental health needs were identified and responses determined in SI after these experiences of internal conflict. Underpinning the study was a concern to learn from national experiences and to help build more effective mental health policy and systems into the future.

Methods

Research approach

This case study forms part of a larger project involving two national case studies (SI and Timor-Leste), each spanning policy, service and community (Figure 1). The case study approach was chosen to facilitate examination of the influences on psychosocial and mental health policy given the diversity of the countries in culture, colonial history, level of development and experience of conflict.

This paper covers the key policy-related questions studied in SI, which focused on understanding how, and by whom, psychosocial and mental health needs were identified and
responses determined and who and what shaped the emerging psychosocial and mental health policies (Box 1).

Data sources and analysis
Data were sourced through perusal of the relevant literature and interviews with key informants. Relevant published literature on mental health in SI and Pacific Island countries was sought, although there was a notable dearth. Unpublished documents (so-called ‘grey literature’) concerning development, governance, policy, planning and health were also sourced and reviewed, including more specific Ministry of Health (MoH) and other agency documentation. All these materials helped build contextual understanding, identifying the key actors and organizations, the processes through which policies and services were established, and key policy developments.

Semi-structured interviews were conducted with 16 key informants from government, bilateral and multilateral institutions, local and international NGOs and the media. Informants were purposively selected for their ability to shed light on the processes of policy formulation and implementation. Interviews covered the key questions (Box 1) while allowing detailed exploration of issues to maximize insights from informants. Interviews were digitally recorded, transcribed, verified, and coded using NVivo 7. A national workshop with local and national stakeholders provided an opportunity for member-checking and assessment of the face validity of the analysis, and stimulated debate around the implications of the research for policy and practice.

Results
Analysis revealed two primary categories of findings: a sequential history of mental health service and policy development, and a detailed overview of the influences impacting on this development: socio-cultural issues; bureaucratic motivation; emerging evidence; political, security and economic concerns; and international aid. The discussion which follows draws on these issues to highlight the influences which helped place mental health policy on the agenda and assisted in driving it forward.

History of mental health and psychosocial policy and services in the Solomon Islands
Mental health and psychosocial services developed gradually over four decades. Formal mental health services in SI date back to 1950, when an asylum was established in Honiara. It was principally a place for custody of persons considered a danger to society or unable to care for themselves. Day-to-day care was provided by untrained staff, with weekly visits by a doctor. The Mental Treatment Ordinance (1970) was introduced ‘...for the safety of society... rather than for the welfare of those affected...’ (P1, policy maker).

In 1977, the Government built a 15-bed mental hospital in the grounds of Kilu’ufi Hospital in Auki, Malaita Province. In 1984, 12 new beds, funded by the British High Commission, were added to accommodate female patients. Like its predecessor, the facility lacked qualified mental health staff and adequate resources. The largely custodial care was provided by general nurses and nurse aides with medical support.

In 1988, as part of a policy to make mental health services more accessible and acceptable, the MoH resumed responsibility for the facility from the provincial medical service, and it was renamed the National Psychiatric Unit (NPU). During the 1990s the country’s first community mental health service was established in Honiara, together with attempts to recruit nursing staff as psychiatric co-ordinators in the provinces. In 1996, the Ministry started sending registered nurses for psychiatric training in Papua New Guinea (PNG). The number of qualified psychiatric nurses increased steadily, from three in
envisaged. The Director at the time of study was an experienced and highly regarded psychiatric nurse with a Masters Degree in Nursing Administration.

In 2005, a National Mental Health Strategy with a 5-year framework for action was adopted (Solomon Islands Ministry of Health & Medical Services 2005b). Developed as part of the HISPT, it was based on an integrated mental health model which spanned the continuum from mental health prevention and promotion to mental health care for those suffering from more serious mental disorders (Solomon Islands Ministry of Health & Medical Services and JTA International 2005).

Public social welfare services in SI date back to the mid-1960s, when increased urbanization brought concern for vulnerable groups. Services were initially focused on Honiara, provided by the City Council. Coverage was subsequently extended and services brought under the MoH. During the early 1970s, responsibility shifted between Health and Home Affairs, eventually coming back to Health, where it remains and is one of the smallest divisions with a total of 10 posts. The Social Welfare Division (SWD) provides juvenile justice and family welfare services, and plays a limited strategic or policy-setting role. The social and welfare needs of the country are mainly met on an ad hoc basis through the churches and civil society organizations (Solomon Islands Ministry of Health & Medical Services 2005a).

None of the many NGOs in the SI focus specifically on mental health although a range of churches, NGOs and some UN agencies deliver some interventions, ranging from a focus on counselling to community development, women, youth and families. Trauma support was provided to people in Guadalcanal and Malaita affected by the conflict (Baron 2004); most programmes were based and focused on Honiara although some had a provincial presence.

Influences on mental health and psychosocial policy in and after conflict

The key influences on mental health and psychosocial policy can be classified into six broad groups: socio-cultural issues; bureaucratic motivation; emerging evidence; political and security issues; economic concerns; and international aid. All had some relevance to the context in which mental health policy change occurred, its content, the processes employed and the range of actors and institutions involved (Box 2).

Socio-cultural influences

Although SI society has followed traditional Melanesian cultural patterns, the research revealed socio-cultural factors reflecting the changing context due to processes of modernization and change. The ‘wantok’ (literally ‘one-talk’) system permeates social relations at family and community levels; extended family obligations have been prioritized over individual needs or responsibility to the workplace or government. We found a great diversity of island and language groups, with over 90 indigenous languages and dialects spoken in addition to SI Pijin and English (the official national language). Traditional allegiances have remained strong:

“. . . Basically, although colonisation came, you still maintain those tribes. So we’re living in two worlds if you like – yes, we are...
Box 2 Key influences on mental health and psychosocial policy

**Socio-cultural factors**
- ‘Wantok’ system—family and clan affiliations
- Diversity of island and language groups
- Cultural health beliefs
- Influence of Christian churches
- Breakdown of traditional value systems, relations and structures
- Changing status of women
- Growing youth population

**Bureaucratic motivation**
- Leadership within the Ministry of Health
- Individuals with training in population health issues
- Individuals with experience and interest in mental health
- Shift in focus to community-based services within primary care framework
- Concern to prevent disease and disability
- Integration and collaboration
- Potential to mobilize additional resources

**Evidence and research**
- Increasing mental disorders including severe disorders and post-traumatic stress
- Increasing urbanization
- Increasing substance abuse and suicide
- Increasing psychosocial problems, e.g. domestic violence, child abuse
- International evidence and advocacy—rising attention to mental health burden of disease and evidence of effective interventions
- Health service reviews
- Community-based research, e.g. national disability survey
- Recognition of value of data and evidence to drive more effective policy

**Political and security influences**
- Honiara riots (2006) highlighting ongoing fragility
- Disaffection with leaders

**Economic influences**
- Increasing poverty
- Unequal development and widening disparities
- Aid dependence
- Investment outflows

**External and International aid**
- Regional Assistance Mission to the Solomon Islands (RAMSI; 2003)
- Health Institution Strengthening Project (HISP)
- Funding for infrastructure and programmes
- Technical advice and support
- International NGOs and UN agencies, e.g. UNICEF, Save the Children Alliance
- WHO—increasing global attention to mental health

Some tribal groups are matriarchal, others patriarchal. Gender roles are clearly prescribed, as are the roles of young people. Women and men experienced and responded to the conflict and its sequelae differently (see also Blignault *et al.* 2009).

In the villages, young people with limited education and high expectations have had few opportunities for employment and participation in decision making, and many have moved to Honiara. Issues affecting youth, notably increasing levels of substance abuse and premarital sex, have posed challenges to government and a health sector anxious to prevent the spread of HIV/AIDS. With 40% of the population below the age of 15 years (UNDP 2008), and nearly the highest fertility rate in the Pacific (Leaby *et al.* 2007), it is a “frustratingly young society” said a Solomon Islander from a local NGO (P6). Youth disaffection is a major concern. Although traditional authority structures were already beginning to break down, assisted by the processes of urbanization and globalization, after the tensions; a lot of young people “just followed their mind, whatever they wanted they could do” (P4, journalist).

Emphasis was repeatedly placed upon the major transitions underway in society:

“...it’s a transition period in the Solomon Islands between a very collective society, with adults still taking a very collective approach, to young people who are actually highly transitioning into an individualistic society and all the needs and all the demands that come with that that aren’t being met.” (P7, expatriate NGO worker)

Patterns of help-seeking for both physical and mental disorders are shaped by traditional beliefs (Solomon Islands Ministry of Health & Medical Services 2006). The latter are often attributed to witchcraft, sorcery and the breaking of taboos (Farobo 1992).

In recent years, there has been increasing recognition that health services are only one of the many resources consulted by people, and this is often done late: “We’re the last resort; if everything else fails they come to us” (P5, health official).

Socio-cultural issues influence both the composition of the policy-making group and the attitudes and values brought to the task of policy making. In 2006, all members of the national parliament and the great majority of senior public servants were men. The ‘male dominated health system’ reflected the male dominated society. In our study, the NGOs seemed more attuned to the needs of women and youth.

Obligation to wantok is taken seriously by all Solomon Islanders at all levels of society. In other respects, however, indigenous community structures and practices, including traditional community mechanisms for coping with stress, have largely been overlooked or ignored by policy makers. The government has expressed an interest in strengthening the chiefly system, and the MoH has acknowledged traditional beliefs as having a major impact on utilization of services, particularly in the provinces (Solomon Islands Ministry of Health & Medical Services 2006).

Civil society played a limited role in setting the agenda, but contributed substantially by working with community structures...
to provide community-based counselling, and attended to issues affecting women, youth and children. The media provided a voice for civil society and focused some attention on the need to reassess development priorities and practices.

The Church, an important and widely respected institution in SI, was also not influential in driving policy, but played an important role in bolstering peripheral services. The Roman Catholic Archbishop of Honiara established the Trauma Support Program, now run by one of several NGOs funded by the Australian Agency for International Development (AusAID). In 2000, “he [recognised how] the ethnic tensions affected the people …and started looking for someone from outside to come and work with us in the Solomons…” (P3, NGO worker). Many senior bureaucrats were also senior church members.

Both indigenous and expatriate informants stressed the importance of appreciating the impact of culture, including wantok, within development settings: “…That’s where some development processes miss out because they have not been able to understand the context, the localities, the struggles and the situation we find ourselves in…” (P8, bureaucrat).

The influence of bureaucratic motivation

The total health budget was not large, equivalent to 5% of GDP (WHO 2005), and many important issues competed for attention, such as malaria and maternal and child health. Key individuals within the MoH and its Executive played an important role in promoting attention to mental health and wellbeing. In particular, leadership and advocacy by the locally respected director of the mental health service, and his predecessors, facilitated movement from a custodial to a community-based model of care and rehabilitation. A policy-maker (P1) emphasized the role of this individual:

“[He] complains all the time about mental health being neglected in this country… It falls on [him]. If [he] is not active, nothing happens in mental health. If [he] is active, something is going to happen.”

The shift to a broader mental health orientation was reinforced by an MoH leader who embraced a population approach, as well as the donor-supported HISP initiative which opened space for population health interventions. Senior policy-makers and planners, a number of whom had completed postgraduate studies in public health, articulated a vision that incorporated the broader determinants of health (Solomon Islands Ministry of Health 1999; Solomon Islands Ministry of Health & Medical Services 2006), and provided leadership for a new agenda. This approach has been expressed as ‘a search that draws together the optimum medical model, public health model and social wellbeing model in a new and comprehensive health and wellbeing paradigm for the Solomon Islands’ (Solomon Islands Ministry of Health & Medical Services 2005).

The 1999–2003 National Health Plan (Solomon Islands Ministry of Health 1999) reflected a shift in focus away from hospitals towards primary care. Although limited attention was devoted to psychosocial and mental health issues, these resurfaced in relation to the ethnic tensions with the associated RAMSI intervention and health reform agenda, and support for mental health, social welfare and community-based rehabilitation was present. A clear agenda was identified, including better coordination and integration of services, improved links with NGOs and churches, and a greater focus on prevention.

In the National Health Strategic Plan 2006–2010 (Solomon Islands Ministry of Health & Medical Services 2006) the public health objective to ‘[s]trengthen social welfare, mental health and community-based rehabilitation and their community-focused approaches’ echoed broader government policy. Senior policy-makers continued to emphasise integration, including a multi-sectoral approach to mental health and psychosocial issues. A senior policy-maker (P9) told us: “Our challenge now is…how best could we make sure that these issues and the policy could be equally recognised within the whole government?”

The influence of evidence and research

In SI the burden to individuals, families and society associated with mental disorders has become increasingly apparent (WHO 2002). A senior policy-maker (P9) remarked: “Since 1998 I could see a trend emerging of mental health and psychosocial health problems increasing side by side”. Arguments for directing attention and resources to this area were based on an increase in the number of patients seen by the mental health services, including severe mental disorders, substance-related disorders and post-traumatic stress disorder (Solomon Islands Ministry of Health 2001; Solomon Islands Ministry of Health & Medical Services and JTA International 2005). Analysis of deaths recorded at the National Referral Hospital in 2004 showed that suicide was one of the 10 leading causes of death (Solomon Islands Ministry of Health & Medical Services and JTA International 2005).

Within the MoH, Solomon Islanders and external advisors made use of routine data, supplemented with surveys and other research, to inform decision-making (Solomon Islands Ministry of Health & Medical Services 2006; Solomon Islands Ministry of Health & Medical Services and JTA International 2006). This shared commitment to valuing evidence provided an opportunity to reinforce attention to underlying and upstream issues: “Under HISP [an externally funded project] we did a lot of national health reviews…a lot of evidence…collection of data and review to actually determine better what the health status is and where the problems are…” (P12, expatriate advisor).

External assistance helped place information and data in the public domain, enabling debate. The reports prepared by foreign consultants for UNICEF (Baron 2004) and the MoH, through the HISP (Solomon Islands Ministry of Health & Medical Services 2005a; Solomon Islands Ministry of Health & Medical Services and JTA International 2005) sought to highlight the voices of communities in the provinces, and to explore how best to respond to growing concerns around psychosocial and mental health. International evidence and experience was consulted and adapted to local context when local data were not available (Solomon Islands Ministry of Health & Medical Services and JTA International 2006).

A bureaucrat from the Ministry of Planning (P8) said:

“I think it’s important to have data as evidence to drive our planning processes and then base our discussions on evidence rather than just talk without any verification or justification as to fact…All sectors must have a data mechanism in place to support the decision-making in policy, in planning, at programme level.”
This informant highlighted the value of data, presented in the right way, in assisting the elected government to set national priorities and negotiate with donors:

“(Usually) donors have done their homework in terms of justifying what to fund and what projects and programmes they have to fund… Our Government shortfall is having that justification in terms of data to make our case and to prioritise…”

**Political and security influences**

Conflict was most apparent in the period 1998–2000, but continued until 2003. During this period, collective violence, manifest by displacement, deaths, rapes and assaults, resulted in widespread tension, distrust and distress.

A number of psychiatric and psychological sequelae were associated with this turmoil and social disruption, including untreated mental disorders, traumatic stress, widespread psychological distress and increased rates of substance misuse and suicide (Solomon Islands Ministry of Health & Medical Services and JTA International 2005). From a health service perspective, the concern was even broader: “the tension caused the collapse of the health system” said a policy maker (P10). Amongst the difficulties experienced had been disruptions in health worker payments, limitations in supplying medicines and closure of some services (Malefoasi 2003). The National Psychiatric Unit was closed for 9 months, while services at the ‘Psychic Clinic’, the community-based service in Honiara, were reduced (Solomon Islands Ministry of Health & Medical Services and JTA International 2005). Transport of patients to Malaita was disrupted and people from other provinces were reluctant to go there. Concerns over access led to increased calls for decentralization of the mental health service (Solomon Islands Ministry of Health 2001).

Socio-political and security challenges led to external intervention, notably through RAMSI. On the back of this security and peacekeeping initiative was ostensibly attention to broader issues of governance and development, albeit with significant limitations (Moore 2005). Nevertheless, reflection during this period provided an opportunity to consider how best to address the determinants of mental health and prevent the recurrence of violence (a concern heightened by riots that followed the election in 2006). An emphasis on young people and on rethinking the pattern of development investments surfaced, along with greater emphasis on equity.

Disaffection with leaders of a new government established after elections in April 2006 led to riots in Honiara, with the Chinese commercial sector being especially targeted due to a perceived nexus with national politics. This renewed instability undermined confidence and rekindled anxieties among vulnerable groups, especially women and those affected by past violence. To some, it seemed that the earlier conflict had increased the sensitivity of people in Guadalcanal to corruption and wrong-doing, and their readiness to react with violence.

Within the broader security context, several of our informants recognized the need to develop links across cultural and other divides, and to take these issues into account in planning services. “Not all Solomon Islanders are enemies” a Solomon Islander from a local NGO (P6) told us. Informants also recognized the potential of strategies that promote healthy lifestyles and “a healthy mind” in reducing the likelihood of future discrimination and conflict.

Thus the context of security needs and reform reinforced efforts to address mental health issues with a focus on the entire population and a particular emphasis on young people.

**Economic influences**

The SI are among the poorest of the Pacific Islands (UNDP 2006). Ongoing economic challenges are significant and, combined with migration to urban areas, present new hurdles to psychosocial wellbeing and mental health:

“You have people coming together, moving together, mobility… I think that’s one of the major causes of mental illness in this country—where people are… Economic drive can do all sorts of things to people. One of the things is break down families and break down communities for the sake of moving forward. But when you talk about any development, how many times do we say what will this kind of development do, or how will this kind of development affect the mental state of people?” (P1, policy maker)

Earlier gains in education and health were eroded by the conflict and subsequent social and economic collapse. Major economic activities, notably large oil plantations, gold mining, logging and some significant agricultural schemes in Guadalcanal, closed following the 1998–99 violence (UNDP 2004). While there has been some emphasis on young people and rural areas, projects have often not been appropriate or sustainable:

“We keep on going ‘Oh, we’re going to have rural approaches to young people’ but they don’t want to be pig farmers. Even if they did it wouldn’t work, we’ve tried it before… We’re 20 years behind the whole pigs and chickens approach to economic advancement, it doesn’t work.” (P7, expatriate NGO worker)

Responding to social and economic changes presents a major challenge for the government, development agencies and donors. The government is “very aware of the volatility of frustrated, disengaged and alienated communities” (P1, policy maker).

**External influences and international aid**

Internal conflict led to foreign intervention. Together, RAMSI and HISP promoted enhanced security and the resumption of services. One HISP expatriate advisor explained:

“When RAMSI came in we actually had an avenue to get drugs and supplies out because they had the planes and the helicopters and the boats. Nothing else was working… RAMSI brought in a whole heap of control mechanisms… People, particularly nurses, felt safe to come to work.” (P10)

The same advisor described how, once the situation stabilized, evidence of the effects of conflict became apparent:

“For me it was very much displaced people and the mental health issues or the psychosocial issues that came with that… (In the
HISP played a valuable role. Some members “had worked in conflict zones before and understood the impact, particularly at the population level, on populations that probably previously had pretty good mental health… also there were a couple of professionals on the team who had worked in mental health” (P2, expatriate advisor). Recognizing the need and opportunity, the HISP team worked to raise the profile of mental health and psychosocial issues within the broader health agenda. This complemented the voices, in national health conferences and other fora, of provincial health workers who identified the need to address psychosocial distress at community level, where it often presented in the context of family violence and substance abuse.

The donor community concentrated on promoting a more stable macro-economic, security and development environment, but also sought to reinforce government leadership through identifying and responding to unmet need and enhancing reform opportunities. Technical advice and funds underpinned government initiatives.

During and especially after the conflict, some of the donors worked with the SI government and the MoH to address psychosocial and mental health issues. Medium-term commitment provided opportunity for relationships of trust to be developed between expatriate and indigenous decision-makers. While the restoration of law and order was widely welcomed, in subsequent years the RAMSI intervention itself became a source of disaffection and stress; concerns were raised that not all parties had been brought to justice and aid and services were not being fairly distributed. The following exchange with a local development worker is illustrative:

P11: “I think the thing that happened is that people felt that the government is not giving enough attention to the provinces, and this belief that people in the hierarchy have been bought-off…”

Interviewer: Mistrust in the leadership…?

P11: “Yes, lots of corruption and that sort of thing. People feel that a lot of aid is coming to the country but they are not seeing a difference in the communities.”

Thus, political tensions led to conflict and instability, which in turn were associated with psychological distress and social unrest. The RAMSI initiative led to enhanced security, new resources, new leadership and support to reform, including in health as manifest by the partnership between HISP and the MoH.

Events in the SI coincided with increased attention to mental health issues globally, following publication of Mental Health: New Understanding, New Hope (WHO 2001). In Honiara, World Mental Health Day 2001 was marked with a march by 200 people through the streets carrying the banner “Stop the Exclusion – Dare to Care”. The Western Pacific Regional Strategy for Mental Health, launched in 2002, had two basic goals: to reduce the burden of mental ill-health and to improve quality of life by promoting mental health (WHO 2002). In SI concern for the psychosocial needs of children and youth post-conflict led to a UNICEF situational analysis and strategic plan (Baron 2004).

Some of the external influences did not necessarily fit comfortably, locally:

“When we talk about rights…it certainly doesn’t seem to fit culturally. That’s been a poor approach in our understanding in how to communicate rights.” (P7, expatriate NGO worker)

The World Health Organization played a modest but supportive role over a 20-year period. International agencies and NGOs attracted additional funding and expertise and provided a base with which government could interact. For a short time, the Psychosocial Network, endorsed by UNICEF and supported by AusAID, provided an important forum for stakeholders, and supported training for counselling at community level.

Policy makers found it difficult to confront foreign donors and advisors whose main concern may be short-term impact rather than sustainability. This reflects the broader asymmetry in power which often characterize donor-recipient country relationships. One expatriate advisor (P12) remarked: “It requires confrontation, standing up and negotiation, which often happens in a roundabout way in this culture”. An SI policy maker agreed, suggesting that nationals may be disadvantaged in their relationships with international actors:

“We don’t have the strength. We are a little bit naive about many things and are easily exploitable. We are vulnerable and we give away ourselves too much. We smile too much to everybody. We’re too kind. We’re just vulnerable.” (P1, policy maker)

Discussion

This paper describes how mental health and psychosocial issues found their way onto the national health and development agenda in SI. Key policy drivers were the three ‘p’s often associated with agenda-setting: the problem, in this case the growing awareness and concern with mental health; the politics, here the instability and violence; and the policy, the ability to respond and improve systems and service provision. In taking these forward, they were underpinned by, and benefited from, support also from three ‘d’s: data in the various forms of evidence including that from research; decision-makers in relation to the bureaucrats and politicians who sought to address mental health; and donors who supported health reforms and enhanced systems, including those for mental health. Together these helped shape the policy agenda and progress it.

Policy development was a process of incremental change, building upon a longstanding but limited concern with mental health and social welfare, along with strong advocacy from within the small mental health service. Armed conflict and ethnic tensions from 1998–2003 were followed by recognition, at least among health-related policy makers and service providers, of unmet mental health needs and psychosocial problems. Earlier advocacy by the World Health Organization around mental health (WHO 2001) may have played some part in underpinning these efforts. Additional support and impetus was garnered through the positioning of key health leaders, some of whom had been trained in population health. These individuals, embracing a population mental health approach
and working with external support, drove the agenda. Contextual factors, notably further violence in 2006 and a growing youth population, along with emerging international and local evidence, intensified efforts.

Dramatic changes in the political, economic and security environments focused policy attention on prior experiences of collective violence, the inadequacies of earlier development strategies and the need to engage with a wider range of development partners. Political fragility reinforced the need to address root causes, among which were unequal development, poor governance, and socio-cultural change. The latter was most apparent in relation to young people who have an increasingly tenuous link to traditional structures and expectations; greater exposure to alternate ways of living, behaving and relating; increased exposure to alcohol and drugs; inadequate access to education, training and employment opportunities; and increased migration to urban areas. Concurrently, the government recognized that ‘right ways’ of thinking and behaving require attention and support at community, provincial and national levels.

National actors built their case around the community burden and the limited public sector response to psychosocial wellbeing and mental health issues. The conflict and its aftermath focused attention on the impact of collective violence: increased post-traumatic stress disorder, substance abuse and suicide; unmet care needs of those with serious mental illnesses; and the value of supporting community responses to psychosocial distress. More recent recognition of the political, economic, social and cultural determinants of health, and of development failures which, if not addressed, risked undermining both psychosocial wellbeing and national security, also played a part. Failure to address the psychosocial concerns of young people was seen by influential policy-makers as potentially explosive.

The availability of international forces and donors funds, in large part associated with RAMSI, assisted in restoring stability, and also facilitated a review of governance and service delivery in sectors such as health. External engagement provided some space in which reflection could take place and new policies, strategies and responses could emerge. External agencies (multilateral, bilateral and non-governmental) provided some support to building capacity and systems, providing extra resources (time, funds, people and technical advice) through which attention to psychosocial wellbeing and mental health issues could occur.

The bureaucracy within SI, probably as a result of increased professionalism, more skilled staff and possibly closer relationships with expatriate advisers and technical experts, identified the importance of various forms of evidence to help drive decision-making. This illustrates the value of efforts to promote evidence-informed policy (Alliance for Health Policy and Systems Research 2007). Better trained civil servants demanded information and data with which to help shape public policy decisions and guide the ministers, who otherwise were more influenced by patronage, wantok and other less ‘objective’ criteria.

Not only has the agenda shifted, but so too has the content of policy (Solomon Islands Ministry of Health & Medical Services 2001; Solomon Islands Ministry of Health & Medical Services 2005b). There has been a welcome shift in focus from custodial care and protection of individuals and the community (already underway before the conflict) to community-based services. Across the health sector, there has been greater awareness of the need to embed mental health within the primary health care framework, as well as to consider prevention and mental health promotion (Solomon Islands Ministry of Health & Medical Services 2006). Increasing recognition of community needs and perspectives (Blignault et al. 2009; MacLaren et al. 2009) will reinforce a trend to ensuring that policy and services are respectful and responsive to communities.

The experience of SI echoes some of the observations from other settings. In Cambodia (Stockwell et al. 2005), Bosnia Herzegovina and Kosovo (De Vries and Klazinga 2006), the cessation of conflict led to an inflow of donor interest and resources, and opportunities to establish and reform the mental health system and associated policies. In both those settings, the drive was primarily from outside, from donors; local ownership, and ultimately sustainability of change, was limited. This differed from the SI experience where donor support and some of the things that may accompany it, such as better data and political momentum to support policy change, were present, but these bolstered an already established albeit under-resourced mental health programme. Donor engagement in an appropriate context may be supportive, as opposed to distorting, and may enhance the confidence and capability of local bureaucrats, policy makers and service providers to promote change. This appears to be the case in SL where local ownership and commitment, from the small number of key people involved, were strong.

**Conclusion**

This case study presents insights into the emergence of mental health and psychosocial policy in a small island state recovering from conflict. The policy analysis undertaken reveals a nationally driven and internationally supported move towards mental health promotion and wellbeing, with a high-level commitment to socio-cultural relevance. Mental health was seen as important for a variety of reasons: it represented a potential problem, was politically sensitive, and policies existed to address it, thus illustrating a clear example of Kingdon’s proposition that three ‘p’s’—problem, politics, and policy—come together to drive agenda setting (Kingdon 1984). These insights were underpinned and reinforced, in this particular setting, by three ‘d’s’: a range of national decision-makers who were sensitive to the issues, donor personnel and resources which were supportive, and data which highlighted the need to revise the policy and extend services—decision makers, donors and data. None alone is likely to have mobilized the momentum to develop and drive the mental health agenda forward.

The positioning of psychosocial and mental health issues is fragile, however, and remains dependent on demonstrating the links between poor mental health and issues of inadequate functioning, family and community instability and violence, and threats to national development. As in many developing country settings, providing an economic rationale for government and donor attention would help consolidate these issues on the national agenda. Over time, the ability to demonstrate that investments in psychosocial wellbeing and mental health
lead to better health and social outcomes will, no doubt, be important.

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This project was approved by the Human Research Ethics Committee of The University of New South Wales, and by the Ministry of Health in the Solomon Islands. Free and informed consent was obtained from all informants. Other key issues negotiated concerned research relationships, respect for confidentiality and culture, engagement by the research team in establishing more meaningful and sustainable links, and the promotion of reciprocity, rights, protection and participation.

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Endnotes

1 Psychosocial problems are individual, family or community problems that have both psychological and social components. Examples include domestic violence, child abuse and poor school retention. Mental disorders negatively affect cognition and/or emotions and are defined by standard diagnostic systems such as the International Classification of Disorders or the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Examples include depression, anxiety disorders, substance-use disorders and schizophrenia.

2 Unless otherwise specified the informants were all nationals from the Solomon Islands.

3 The term ‘psychosocial’ was introduced and promoted in the Solomon Islands by UNICEF, initially through Nancy Baron’s influential report and then through the Psychosocial Network that operated in the Solomon Islands.

References


