Mental health in Africa: the role of the WPA

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Africa is a large continent, prone to strife, especially south of the Sahara. Most of its countries are characterized by low incomes, high prevalence of communicable diseases and malnutrition, low life expectancy and poorly staffed services (1,2). Mental health issues often come last on the list of priorities for policy makers (3). Where mortality is still mostly the result of infectious diseases and malnutrition, the morbidity and disablement due to mental illness receive very little attention from the government. Health in general is still a poorly funded area of social services in most African countries (1) and, compared to other areas of health, mental health services are poorly developed. Indeed, most African countries have no mental health policies, programs or action plans (4,5). In 1988 and 1990, the member states in the African Region of the World Health Organization (WHO) adopted two resolutions to improve mental health services, and each state was expected to formulate mental health policies, programs and action plans. A survey was conducted two years later to see if the countries that had adopted these resolutions had done anything to implement them. Despite some modest achievements, the situation of mental health programs in most countries was found to be unsatisfactory (4). Compelling evidence shows that a large proportion of the global health burden is due to mental disorders, and this proportion is projected to rise in many African countries (6).

In its African Regional Strategy for Mental Health in the year 2000, the WHO emphasizes that populations in the African region are beset by numerous mental and neurological disorders that are a major cause of disability. Furthermore, there is a lack of reliable information systems in most countries. However, some primary observations and estimates can be made:

- In many African countries, the most frequent presentation of psychosis is acute or subacute: acute transient psychoses, paranoid psychoses, psychoses resulting from cerebral involvement in infectious diseases, like malaria, typhoid fever or human immunodeficiency virus (HIV) infection. These conditions produce only temporary disability, but cause much suffering and can have chronic consequences if not properly treated.
- The prevalence of epilepsy is high, largely due to inadequate care at childbirth, malnutrition, malaria and parasitic diseases. Epilepsy is still highly stigmatized, particularly because it is often considered infectious, which leads to the social isolation of the sufferer.
- Half of the population of the region is made up of children below age of 15 years. It is estimated that, of those aged 0-9 years, about 3% suffer from a mental disorder. Many children suffer from poor psychosocial development because of neglect by their mothers and other caretakers. Brain damage is one of the main causes of serious mental retardation.
- The population of elderly people is still low, with only 3-4% of the total population aged above 65 years. While the prevalence of dementia is therefore not very high, other brain syndromes, which usually follow an infection or trauma of the central nervous system, are common in the African region.
- Many countries in the African region are engulfed in conflicts and civil strife, with the attendant adverse impact on the mental health and well-being of the affected populations, foremost post-traumatic stress disorder.
- Alcohol, tobacco and drug related problems are becoming an increasing concern in the region. Many of the countries in Africa are used as transit points for illicit drug trade and these drugs are finding their way into local populations, adding to the indigenous problems associated with cannabis consumption. There is an increased demand for home-brewed beer or locally distilled liquor. In most countries there are no national policies on alcohol or tobacco; consequently, their advertising, distribution and sale are largely uncontrolled.
- Increasing poverty, natural disasters, wars and other forms of violence and social unrest are major causes of growing psychosocial problems, which include alcohol and drug abuse, prostitution, street children, child abuse and domestic violence.
- HIV infection has added considerably to the psychosocial problems already being experienced in many countries of the region, creating a need for extra support and counseling for those affected and care for their surviving family members, especially children. In parts of southern Africa the prevalence of HIV in the general population exceeds 30% (7) and over 90% of those cases are attributable to heterosexual activity. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO estimates, 7 out of 10 people newly infected with HIV in 1998 live in sub-Saharan Africa; among children under 15, the proportion is 9 out of 10. Of all deaths from acquired immune deficiency syndrome (AIDS)

since the epidemic started, 83% have been in this region. At least 95% of all AIDS orphans have been African. Since the start of the epidemic, an estimated 34 million people living in sub-Saharan Africa have been infected with HIV. Some 11.5 million of those people have already died, a quarter of them children. In Botswana, Namibia, Swaziland and Zimbabwe, current estimates show that over one person in five between the ages of 15 and 40 is living with HIV infection. 1.6 million Zimbabweans have contracted HIV infection since the beginning of the epidemic; 400 thousand of them have developed AIDS, 300 thousand have already died, about 800 people die every week and 2000 get infected every week.

For several years it has been the concern and strategic commitment of the WPA to help the development of psychiatry and mental health care in the regions where they encounter the greatest difficulties in the world, namely sub-Saharan Africa and Central Asia. On that matter the WPA decided to work in close collaboration with WHO for a number of projects, including the WPA program for promoting mental health services in sub-Saharan Africa and Central Asia. The objectives of this program are to strengthen mental health policies and adopting and implementing regional strategies to prompt mental health and prevent mental, neurological and psychosocial disorders and drug abuse-related problems; to reduce disability associated with neurological, mental and psychosocial disorders through community-based rehabilitation, and to reduce the use of psychoactive substances (alcohol, tobacco and other drugs). On a public level, it is the objective of the program to change people's negative perceptions of mental and neurological disorders, to formulate or review existing legislation in support of mental health and the prevention of substance abuse and to provide equitable access to cost-effective mental, neurological and psychosocial care.

Milestones on the road to that overall goal include the achievement of a change in the negative perception of and attitudes to mental disorders by the public as well as the policy makers. People's attitudes are usually influenced by traditional beliefs in supernatural causes and remedies, and this belief system often leads to an unhelpful or health-damaging response to mental illness, stigmatization of mentally ill persons and those who attempt suicide, and reluctance or delay in seeking appropriate care for these problems.

Furthermore, the WPA targets the maximization of the scarce public resources and support of families in the provision of the best possible care for the mentally ill. The fact that mental disorders are among the top ten causes of disability in Africa and the rest of the world, and that their contribution to the overall burden of disease is going to rise, makes a strong case for giving them the attention and resources they need. Policy makers need to stress the cost-benefit ratio of treating persons with mental illness and making them active participants in national economic activities. Patients with mental illness are easily marginalized by the social services, including health care services. Shortage of money, staff and facilities make unequal access to care more likely, but equity is about the way the available resources are distributed, however inadequate.

Another goal of the WPA program is the initiation of mental health policies and their integration in primary health care, the adoption of mental health legislation and securing equity in the provision of mental health services and adequate care for mentally ill through proper funding of those services.

In the early 1990s, only 23% of member states of the African Region of WHO were reported to have a mental health legislation. Mental health legislation in Africa must be brought up to date. The human rights of the mentally ill must be given prominence with relevant legal provisions. What is needed is a broad view of mental illness as a major cause of morbidity and a burden to victims, their families, and society. An integrated mental health policy reduces morbidity and burden by emphasizing primary and secondary prevention and all forms of mental rehabilitative care of the more severely ill. Policy goals may include bringing families with mentally ill members together, encouraging the creation of consumer groups, and developing broader views of rehabilitation.

In January 2001, African leaders of psychiatry were invited by the WPA program for promoting mental health in sub-Saharan Africa and Central Asia to meet in Cairo to discuss the current mental health situation in the continent and agree on a plan of cooperation within the framework of the WHO/WPA collaboration. The meeting was attended by psychiatrists from Egypt, Morocco, South Africa, Ethiopia, Uganda, Nigeria, Sudan, Zimbabwe and Kenya, in addition to three members of the Executive Committee of the WPA, representatives of the World Bank and the President of the World Federation of Mental Health. Several presentations revealed the problems both in services provision and mental health status in Africa (Table 1).

While the European Region of the WHO has more than 86 thousand psychiatrists and 280 thousand psychiatric nurses for a population of 840 million, countries in the African Region have only about 1200 psychiatrists and 12,000 psychiatric nurses for a population of about 620 million. The average number of psychiatrists is 9/100,000 population in the European Region and 0.05/100,000 population in the African Region. In several African countries mental health services are provided by psychiatric nurses. For instance, in Ethiopia all psychiatric clinics are run by nurses; they prescribe medications and treat acute conditions.

The WPA recognizes a number of constraints to the development of mental health programs in Africa:

- Lack of awareness of the magnitude of the problem.
- Lack of a reliable information system. Information on the efficiency and cost of various forms of intervention is needed to permit enlightened planning and allocation of resources. Questions about the prevalence in communities of common disorders of childhood or old age, or about substance use, or about factors associated with the HIV/AIDS pandemic are largely unanswerable in most African countries. Also in the allocation of scarce resources, prioritization is essential. Research is needed to determine the best policy for the particular country concerned, prevailing social and cultural circumstances, the main constraints, and the options for a viable model of care within them.

Table 1 Mental health resources in some African countries (updated September 2000)

Country	Population (million)	Psychiatrists (n.)	Psychologists (n.)	Psychiatric nurses (n.)	Psychiatric hospitals (beds)	Mental health act	Mental health policy
Botswana	1.7	5	1	55	1 (162)	yes	yes
Egypt	65.0	700	2400	1355	14 (9700)	yes	yes
Eritrea	4.2	1	1	7	1 (160)	no	yes
Ethiopia	64.0	10	2	144	1 (360)	no	no
Kenya	32.0	35	2	1100	1 (500)	yes	yes
Mozambique	17.0	4	5	34	2 (460)	no	yes
Namibia	1.5	3	10		1 (50)	yes	yes
Nigeria	128.0	70	14	7200	8 (4000)	yes	yes
South Africa	45.0	350	4179 clinical 1507	7000	15 (7500)	yes	no
Swaziland	1.0	1	2	30	1 (150)	yes	no
Tanzania	34.0	10	2	1232	1 (1600)	yes	yes
Uganda	22.0	9	5	400	1 (450)	yes	no
Zambia	1.0	5	2	640	1 (470)	yes	yes
Zimbabwe	12.5	10	15	500	3 (1720)	yes	yes

- Insufficient human and financial resources.
- Absence of national mental health policies.
- Shortage of specialized personnel.
- Constant brain drain.
- Widespread civil strife and violence. Wars and internecine strife disrupt social and community life and spread hunger, disease and homelessness. Psychological morbidity usually accompanies and outlasts the physical morbidity of war.

Although most African societies are fortunate in still being able to draw on the support of families for the care of the mentally ill, urbanization is becoming more widespread and the system of extended families is breaking down, depriving mental patients from a traditional source of support.

Another challenge in African countries is the role played by traditional healers. Many of them are strongly against any medication intake and therefore constitute an obstacle rather than an asset to mental health care provision. In many cases traditional treatments are characterized by injurious methods. In Nigeria about 20% of patients with mental disorders had previously consulted a traditional healer before consulting a general practitioner or psychiatrist; the corresponding percentage in Egypt is 70% (5). How could this be turned from a challenge to an asset? A policy of integration ought to have among its goals an examination of the nature of traditional practices and a process of isolating and improving the more efficacious and safe components of this form of care. WHO has training packages specifically designed for primary care workers, focusing on such conditions as depression, anxiety, somatization disorders and substance abuse. An equivalent tool for traditional healers could be considered.

In view of the above-mentioned challenges and the ambitious endeavors for the future, African leaders of psychiatry have agreed to create the African Association of Psychiatry and Allied Professions, in an attempt to coordinate and join efforts in analyzing, planning and promoting the situation of mental health and mental health care in Africa. All the participants in the above-mentioned meeting in Cairo agreed about the importance of initiating this Association, despite the difficulties existing, especially in communication. It was considered essential:

- to create a network for collecting and disseminating relevant information in the fields of psychiatry and mental health;
- to make contacts with policy makers (especially ministers of health) with the help of WHO;
- to associate French and Portuguese speaking African psychiatrists and to encourage regional meetings in West Africa;
- to maintain close liaison with the respective ministers of health, especially before they go to Geneva for the World Health Assembly;
- to collect information about national mental health programs and legislation, with the help of the World Bank (mapping mental health needs in Africa);
- to support training activities, especially by disseminating WPA educational programs;
- to encourage the creation of national psychiatric associations and their affiliation to the WPA (Kenyan, Sudanese, and Ethiopian associations are willing to join the WPA);
- to organize scientific meetings within regional and international scientific activities to bring forward the mental health concerns of the continent;
- to find contacts with expatriate African psychiatrists, especially if they have an association, in order to help their counterparts working in the country of origin;
- to encourage the help given to academic libraries in Africa;
- to encourage and facilitate the attendance of African psychiatrists in African meetings.

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