

# Public and community health psychiatry in Africa: from humble beginnings to a promising future

There is clear and unambiguous evidence of the magnitude of mental disorders globally – as one in every four persons will develop a mental disorder at some point in their lifetime.<sup>1</sup> Neuropsychiatric disorders are the most important cause of Years Lost due to Disability (YLD).<sup>2</sup> It has been estimated that unipolar depression will be the second most important cause of disability worldwide by the year 2020.<sup>3</sup> While a huge gap has been identified between the prevalence of mental disorders and the actual estimate of patients receiving any form of treatment globally, this gap is more pronounced in low and middle income countries - where most African countries belong.<sup>4</sup>

The trend towards community-based mental health services has garnered a lot of support from the World Psychiatric Association (WPA), with recommendations for a balanced-care approach that incorporates an optimal mix of community-based services with maintenance of indicated number of hospital beds.<sup>5</sup> This universal trend that began about the second half of the last century has also featured significant contributions from Africa. Whilst sub specialization in psychiatry in Africa has obvious human resource challenges, the benefits can be argued to outweigh the disadvantages.<sup>6</sup> This editorial will attempt to review the contributions and the challenges confronting the development of public and community psychiatry as a sub-specialty in Africa.

## History

The traditional African society typically provides an extensive network of support to those with mental illness. The extended family systems ensure that the mentally ill are often living with and are being cared for by their families, with the exception of the most extreme of situations, in which they may be abandoned to wander as vagrants on the streets.<sup>7</sup> Traditional and religious healers also play a significant though sometimes controversial role in the provision of mental health services.<sup>8</sup> The evolution of public and community mental health services in Africa has largely occurred in two phases.

### Phase I (1950s – 1960s)

The pioneers of modern psychiatry on the African continent made significant efforts to establish community based services that would not only be acceptable but also highly effective. They also strove to collaborate with traditional and religious healers. The notable examples include the Aro model village system developed in 1954 by Thomas Lambo and refined by Tolani Asuni in Nigeria.<sup>9,10</sup> Other examples include Margaret Field in Ghana; Henri Collomb in Senegal and Tigani El Mahi and Taha Baasher who developed relationships with Muslim leaders to facilitate identification, referral and de stigmatization of person with mental illness in Sudan.<sup>7</sup>

### Phase II (1970s till date)

This phase has primarily focused on the integration of mental health care into the existing structure of primary health care services, as proposed by the World Health Organization (WHO) in 1975.<sup>11</sup> Egypt and Sudan were involved in piloting the WHO project "Strategies for extending Mental Health into Primary Health Care" from 1975 -1981. This principle of decentralization of mental health services has been sustained in the Sudan, with community psychiatry well entrenched as

a key component of the medical curriculum.<sup>12</sup>

Nigeria, South Africa, Kenya, Ethiopia, Zambia, Botswana and Tunisia are examples of other countries that have made significant efforts to incorporate and train primary care workers to deliver mental health services. Kenya, for example, is currently running a 5-year cycle of mental health training for primary care workers (2005-2010), in collaboration with the Institute of Psychiatry, London.<sup>13</sup>

## Achievements

Public and community health psychiatry in Africa has contributed significantly in the areas of service, teaching and research. These contributions have not been limited to the provision of easily accessible and affordable service to people with mental illness in the community; but have also included several publications investigating the usefulness of these services and providing evidence of their benefits. This has lent even greater credence to previously known facts, for example, the understanding that the socio-cultural environment of the individual is not only important in the etiology and manifestation of psychiatric disorders but also influences treatment outcome.<sup>14,15</sup> The successes of these early experiments sensitized the entire continent of the need to situate mental health care services within the community, in such a manner as to achieve a balance between western science and the socio-economic and cultural realities of the people.

Against the backdrop of a dearth of professionals in the mental health field in Africa, the Lancet global mental health group advocated for increased research and training geared towards service delivery by non-mental health professionals in the community, as a form of "task-shifting".<sup>16</sup> This has been embraced by psychiatrists with public and community training with attendant improvement in not only the number of new services being developed but also hopefully in the quality of services rendered. Significant progress has been made in the process of integrating mental health into primary health care in Uganda and Botswana through training of primary care workers.<sup>17,18</sup> The quality of pre-service training received by community health workers on mental health is also been addressed by training their tutors; an initiative been supported by the WPA in Nigeria.<sup>19</sup>

South Africa is a step ahead of most other African countries, having secured legislative backing for both the development of community-based mental health services as well as to assist support systems that promote user's recovery and re-integration into society.<sup>20</sup> Despite the poor implementation of the provisions of this legislation some areas are already benefiting from specialist mental health services in primary care centres.<sup>21,22</sup>

Mental health policies are in different stages of development in many African countries with most making provisions for decentralization of services, supervision and health decision making.<sup>23</sup> A number of small but significant projects had demonstrated the practicability and cost-effective nature of integrating mental health into primary health care delivery.<sup>4,24</sup> Furthermore, programs funded by non-governmental organisations for the improvement of community-based mental health services have been reported to show sustained good results after several years; it is also note worthy that half of South Africa's community based residential facilities (in addition to some

other mental health services) are being provided by the South African Federation for Mental Health (an NGO).<sup>25,23</sup>

### Challenges

The African psychiatrist today is often constrained by the fact that there are few of them on ground, hence making sub-specialization often an unaffordable luxury. While this affects all sub-specialties, we briefly discuss some of the factors responsible for the slow growth of community psychiatry as a subspecialty in Africa.

Allocation of financial resources to mental health in most African countries is grossly inadequate. This may be partly attributable to the low budgetary allocation from the health budget. The allocation to mental health of the total government health budgets in Africa rarely exceeds 1% , with Ghana (6%) being the exception.<sup>23,26,27</sup> The bulk of this allocation to mental health in our opinion, is inappropriately consumed by the large 'stand alone' psychiatric hospitals with little or nothing allocated to community mental health services.<sup>18</sup> There is an urgent need to demand greater budgetary allocation to mental health in general and community oriented mental health services in particular.

The development of community psychiatry as a subspecialty is further hampered by the non availability of mental health professionals, essential for the multidisciplinary approach to service delivery in the community. Not only are psychiatrists few in many African countries; psychiatric nurses, social workers, clinical psychologists and occupational therapists are also very scarce in most African countries.<sup>7</sup>

In the absence of a formal sub-specialty residency training program in community psychiatry in Africa, most psychiatrists currently working in the community or primary care are actually trained as general psychiatrists. Most had their residency training in 'stand alone' psychiatric hospitals where most patients present with features of the severe end of the spectrum of mental disorders. Working in the community where most disorders are more in the mild to moderate range poses a clinical challenge. Community engagement and mobilization skills which are central to community participation have to be acquired through structured training programs at all levels of medical education.

Although mental health policies exist in about half of African countries; most are rarely or poorly implemented.<sup>23,28</sup> The development and vibrancy of a subspecialty which interfaces with several other government and non-governmental agencies is considerably restrained in the absence of clear policies and implementation guidelines.

### Conclusion

The robust history of community based mental health services as well as the commitment and innovativeness of the present practitioners and the benefit of hindsight which will help avoid mistakes and failures of efforts elsewhere suggests a promising future for public and community health psychiatry in Africa. It is hoped that with continuing advocacy and efforts, governments' attention would be drawn to the development and implementation of relevant policies and programs for community mental health care services.

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