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EXECUTIVE COMMITTEE

FROM THE EDITOR
A WELCOME TO OUR EVER-INCREASING READERSHIP

I wish to welcome you all to the first quarter edition of your Newsletter for 2011.

2011 is already shaping up to be a hectic year in the mental health field in Africa. The burdens imposed on the mental health resources on our continent by various political events are almost impossible to imagine from the outside. Think, for instance, of the amount of stress people have had to live under in the past few months in a place like Ivory Coast – a country, like others in the continent, not known for the vastness of its resources in mental health care.

Three issues are in focus in this edition. The poor condition of the mentally ill in the African continent is almost a cliché in terms of how general the assumption is. The classical problems posed by this line of thinking came to the fore recently with a CNN documentary which purported to show the hopelessness of the conditions in major mental health institution in Nairobi Kenya, and painted a bleak picture of the mental health services, as well as the prospects and quality of life of people afflicted with mental and neurological conditions in that African nation. A number of the dedicated mental health professionals in that country took umbrage at what they perceived as the absence balance, and the overwhelming sense of hopelessness and helplessness portrayed in the CNN documentary. While the facts presented were by and large incontestable, there was a failure to showcase the work – in terms of training, research and innovative service, being put on the ground by Kenyan mental health care practitioners to anticipate and meet the needs of their people despite the resource-challenge they face continually. The piece from David Ndetei in this edition presents a realistic picture of what is on the ground. Not enough, by any means. But certainly not without vision, or hope.

In order for Mental Health care all over the world to receive the resources necessary to deal with the problem posed by mental illness in every society as the most incapacitating (as defined by DALYs) group of conditions known to man, it is necessary that it be kept at a level of visibility in the most exalted circles. The UN is preparing ground for a Health summit of Heads of States on Non-Communicable Diseases. This is planned to take place in Geneva in September 2011. In preparation for this, the WHO in various regions has organised meetings to develop materials and positions. The truth, of course, is that no matter how

passionate mental health practitioners wax on the subject of mental health care, resources are allocated by politicians. If the politicians do not buy-in, as they say, it is unlikely that any additional resources will be forthcoming for work in the field. Such a regional summit took place recently in Brazzaville, Congo. A strong effort was made to put Mental Health on the agenda for the September Heads of States summit. Julian Eaton presents a report on it.

Finally there is a dearth of Advocacy effort in Africa. The challenges of mental health care are vast, and a lot of them reside in the minds of the people themselves, meaning the general population, the leaders, and the mentally ill. There is no continent of the world where there is a greater need for home-grown advocacy effort than Africa. And yet Advocacy is very thin on the ground. The necessary approach is not a distressed wringing of the hands but a deliberate decision to celebrate those who have already taken up the burden, as a way of encouraging others to jump into the fray. Yewande Oshodi is a young psychiatrist who has taken up the challenge, and is already working to good effect, using her own resources and goodwill garnered from her social contacts.

I hope you will enjoy this edition, and be stimulated by it.

OLUFEMI OLUGBILE

MENTAL HEALTH CHALLENGES AND PROSPECTS IN KENYA

Today Kenya has 77 psychiatrists, 418 mental health nurses and 30 clinical psychologists and a much bigger number of counseling psychologists for a population of just below 40 million. Kenya has been lucky in that for more than 20 years there has hardly been any external immigration of psychiatrists but internal migration has led to inequitable distribution of the psychiatrists, with the majority in urban areas. Nearly all of these psychiatrists except 7 have been trained at the Department of Psychiatry, University of Nairobi, the only institution that trains psychiatrists in Kenya. The number of psychiatrists currently being trained is just under 20 and a similar number of clinical psychologists; also postgraduate diploma in substance use, psychiatric social work and Psychotrauma, all at the same Department. The same Department has trained and continues to train psychiatrists and mental health personnel for Rwanda, Tanzania, Zambia, Namibia, Southern Sudan and Somalia. There are several institutions, both public and private that are training on Counseling Psychology at undergraduate and Masters Level.

There are 2 fully developed public medical schools (and several others at various stages of development) with a yearly turn over of about 500 doctors who had to pass a University Examination in Psychiatry before graduation. There is a mid-level college that trains psychiatric nurses but it is facing challenge of attracting students because increasingly more students are opting for University level education. We have no training in the equivalent of clinical officers in psychiatry although talk about this has been on the offing for sometime.

At policy level, Kenya has a Director of Mental Health who sits at the Ministry of Health Headquarters, with the title of a Deputy Director of Medical Services. He has a Deputy who is a Psychiatrist and also a Psychiatrist nurse and occupational therapists to assist him. Although there is a Mental Health Act, there is no mental health policy but there are attempts to fast-track and finalize it. The budgetary allocation for mental health is inadequate (about 0.02% of the total medical services budget). The rest of the mental health aspects in Kenya can be obtained from the now outdated WHO Mental Health Atlas (2005).

Apart from Human Resource development and the move toward mental health policy in Kenya there is a past emerging mental health research and advocacy. This is mainly through the civil society in collaboration with international bodies (civil and universities) with very strong Government support and good will. A few examples will suffice. The BasicNeed UK in Kenya has been involved in Advocacy and Governance in relation to mental health. It advocates for people with all kinds of mental disability including intellectual abilities and epilepsy. It is functional in several areas of Kenya. The User Movement in Kenya is nationally and internationally recognized for its advocacy for people with mental illness. The Kenya Association of people With Epilepsy (KAWE) is involved at community level to support people with epilepsy. The Alzheimer's Association of Kenya, a movement of caregivers for relatives with Alzheimer's disease under the auspices of Africa Mental Health Foundation (AMHF) is fast gaining influence. The Samaritans Kenya group under the auspices AMHF seeks to reach out for people who are suicidal. There is a vibrant medical Board at Mathari Hospital that has over the last 20 years transformed Mathari Hospital so that same of wards parallel and compete for patients with some of the private beds in the city of Nairobi. Other aspects aimed at de-stigmatization of mental illness include the yearly observances of mental health day at all levels of medical services culminating in National observance, mental health radio and TV shows and various publications.

There is active research going on several aspects of mental health led mainly by AMHF in collaboration with various Government Departments and several research organizations both locally and internationally. Of note is the community based Task Shifting aimed at addressing amongst others stigma towards mental illness and delivering services beyond the health centre to the family level.

Like most LMIC countries all over the world, we still have a long way to go in reducing the treatment gap. This will

have to be done through innovative ways that cannot afford to adopt the model being applied in the resource rich Western countries, but a model that seeks to map out and mobilize the resources that we already have and provide appropriate skills. It is possible that taking this approach, it should be possible, in the very near future, to significantly reduce the treatment of gap.

DAVID NDETEI

MENTAL HEALTH - AN ESSENTIAL PART OF REDUCING NON-COMMUNICABLE DISEASE BURDEN THE AFRICA NON-COMMUNICABLE DISEASE MINISTERIAL MEETING, BRAZZAVILLE, APRIL 3RD-6TH 2011

In September 2011, the UN will hold a High Level Summit on Non-Communicable Diseases in New York. The meeting is expected to attract heads of state from around the world, and is only the second time in its 60 year history that the UN has held such a summit on health. Prior to this, Ministerial conferences were planned in each WHO Region to prepare for a meeting at the end of April in Moscow, where the main preparation and negotiations for the New York Summit will take place.

The reasons for such a strong focus on NCDs are compelling. The World Economic Forum Global Risk Assessment 2009 put NCDs as the health area with by far the greatest macro-economic impact. In 2005, 70% of all deaths world-wide were from NCDs, and 80% of these were in Low and Middle Income Countries.[1] The situation is so serious that if unchecked, major development goals such as poverty reduction will be derailed as well s the health-related Millennium Development Goals. Despite the continued high levels of communicable disease burden in Africa, NCDs are rapidly becoming more significant even here – a shift that is mirroring the NCD epidemic that has already occurred in richer countries. The cause of this is changing lifestyles that expose people to risk factors such as tobacco smoke, alcohol, poor diet, obesity and lack of exercise, as well as environmental pollutants. These have been particularly targeted as they are modifiable and common to the four major identified NCDs; cardiovascular disease, diabetes, cancer and chronic respiratory disease.[2]

Despite the fact that neuropsychiatric disorders cause the greatest burden of disease of all the non-communicable diseases as measured by disability adjusted life years (DALYs) at 28% of the total NCD burden[3], at present, it is not included on the agenda at the UN Summit in September. In response to this, African psychiatrists have been at the forefront of lobbying their respective Ministers of Health to try to get mental health on the agenda at the African WHO Ministerial meeting that was held in Brazzaville, Congo, from 4th-6th April 2011.

Following two days of intense debate, mental health was eventually included in the Declaration issued from the meeting. This was despite some strong arguments that mental health has not historically been part of the NCD community as it did not share all of the common risk factors listed above. In fact, mental disorders share many risk factors with the other NCDs and are a mediating factor in lifestyle risk factors like tobacco and alcohol consumption.

There are also strong associations between mental disorders and NCDs, for example depression is a common consequence of NCDs such as CVD and cancer.[4] There are also many opportunities of integrating care for chronic diseases such as diabetes and hypertension and mental health, as service models share many of the same characteristics.

Realistically, it is unlikely that mental health will play a prominent role in the High Level Summit in New York, but perhaps it will be possible to be a part of the discussions about investing in major future initiatives in NCDs. This way, better mental health care can help to ensure that Africans don't inevitably suffer the same consequences of unhealthy modern lifestyles.

JULIAN EATON
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'THE M.I.N.D TRUST PROJECT - THE ROLE OF ADVOCACY GROUPS IN TAKING MENTAL HEALTH TO THE GRASSROOTS IN AFRICA'?

Mental Health Advocacy groups have been well known to contribute positively to improving mental health policies, improving services and reducing stigma.[1,2,3] In developing countries these groups are however few as most NGOs tend to focus more on Poverty alleviation, HIV, gender issues and maternal and child wellbeing. Mental health is often of last importance in the minds of most people. Needless to say this is a wrong disposition seeing that Mental wellbeing on its own has a major interplay with achieving the MDGs that developing nations strive so hard to attain.[4,5]

MIND Trust (acronym for Mental Health Information Network and Development Trust), is an NGO registered in 2008 under the corporate affairs commission of Abuja, Nigeria. It has been one of the few groups in Lagos, Nigeria, working in the area of mental health promotion. Its activities have been centered on using awareness creation, advocacy and care as instruments towards achieving its goals. The group is made up of a few members who are from varying works of life, they include Psychiatrists, Social workers, a Pastor, University students and other lay persons from the community. Currently all the members are actively employed in other regular work and participate in the NGO only on part time basis.

Activities so far have included; Mental health awareness and drug abuse prevention lectures to public secondary schools, donation of some drugs and psychotropic medications to long stay rehabilitation centers in the state, offering of free consultation services to such centers, collaboration along with a donor and a hospital on getting care for a mentally ill vagrant taken off the street; this was followed by a successsfull reuniting of the woman to her family, participation in a medical fair and having a stand that provided information on mental health.

Every World Mental Health Day, since 2008, has been also marked with some relevant event. In 2008 an awareness lecture held at the Lagos state University Teaching Hospital focusing on the theme for that year on 'Advocacy for Global Mental Health: Scaling Up Services through Citizen Advocacy and Action' , while in 2009 another awareness lecture held at the Lagos University Teaching Hospital (LUTH) – focusing on the integration of mental health into primary care. In attendance were members of the academic community surrounding community health service providers and media personnel. In 2010, an innovative effort to mark the event was employed using social media. This was tagged 'Campaign 10-10-10 'and ran from 1st till the 10th of October 2010. In this campaign the MINDTrust Team ensured that people were being informed about promoting their mental health via television interviews, Radio call in programs, daily face book tagging with tips to over 200 contacts, text messaging of mental health promotion tips to over 500 contacts daily for 10 days. This turned out to be a very successful exercise with far reaching impacts even beyond Lagos.

MIND Trust is a group still at its infancy, grappling with challenges of improving structure, committed human resource and funding. Response from corporate bodies has also been poor regarding sponsorship of other larger scale activities. This limited support may be borne out of stigma, or the perception of mental health not being as attractive as other projects for sponsorship. The Organisation remains undeterred and will continue to take consistent but maybe little steps in an effort to make mental health a priority in its environment.

It appears however that the time is ripe for ; creation of more mental health advocacy groups (User led and Professional) in Africa, more funding of such groups, more volunteer involvement, more donor support, and more Government response to such groups. This is definitely an important way forward for Mental Health in Africa now.

YEWANDE OSHODI

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