

# **Mental health in Africa: time for action. Report of the annual conference of the Association of African Psychiatrists & Allied Health Professions, April 24–25 2006, Addis Ababa, Ethiopia**

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The number of psychiatrists in many African countries is strikingly low. Therefore, these few professionals are often overburdened and have an isolated and marginalized position. So, it was commendable to see the establishment of the Association of African Psychiatrists & Allied Health Professions (AAPAP) by a group of active African psychiatrists. This organization aims to unite psychiatrists working within the African continent, and to improve the African mental health care system. The annual AAPAP conference was held in Addis Ababa, Ethiopia and was attended by nearly 200 participants from Africa, and beyond. In his opening speech, Mesfin Araya, recalled the remarkable growth of psychiatry in Ethiopia. In the 1970's, when Dutch psychiatrist Robert Giel started his pioneering work, there were no psychiatric facilities apart from one huge asylum where no one wished to go. These days there are dozens of qualified psychiatrists, 300 psychiatric nurses and 40 psychiatric clinics. A significant part of the health budget is now allocated to mental health. In 2002, the country started its own postgraduate training in psychiatry.

While not dismissing the encouragement of the Ethiopian example, Norman Sartorius, former Director of the World Health Organization's (WHO) Department of Mental Health was cautious, if not pessimistic. He pointed out that mental health care in Africa has to be delivered within worrying general trends, such as: violent conflicts, environmental degradation, increasing gaps between rich and poor, and a decreased trust in governments. On top of this, mental health care faces the challenges of all health care sectors in Africa: brain drain, deterioration of public services, and general increases in morbidity and mortality. Mental health care professionals will only be able to overcome these challenges by a sharper definition of priorities and creative new ideas.

Sartorius advocated a drastic re-appraisal of the role of the private sector. This sector cannot be neglected any longer and needs to be connected to the formal health care system. Sartorius also appealed for the development of an urban mental health doctrine. Frequently, the focus is on 'rural' health care while the marginalised people residing in urban slums are ignored more and more often.

David Goldberg (London) emphasised the need to train general practitioners to identify common mental disorders. He also pointed out that the role of psychiatrists has to change, as they cannot do all of the work themselves. Psychiatrists must encourage and organize training courses for other medical personnel, and concentrate on supervising and coordinating roles.

This approach is hardly new but obviously needs constant reiteration. A relatively prosperous country like Kenya (35 million inhabitants) has 72 psychiatrists, but almost all work in isolation in private practice in the capital. The vast majority of Kenyans are therefore deprived of psychiatric care. In other African countries, the approach of mental health within the primary health care system has been seriously applied. For example, in Tanzania (37 million inhabitants, 14 psychiatrists) impressive results have been achieved. Psychiatrist Marian Muller explained how trainings occurring extensively throughout the country have been organized and a supervision system (integrated within the existing structures) has been set up. The Tanzanian experience shows that mental health care can be made an integral component of primary health care, even with rather modest means. It also shows that it is not a panacea. For example, before training, health workers identified less than 1% of the presented mental health cases. Two weeks after training this had been increased to 25%. Is this an improvement? Yes. Is this sufficient? No.

One might argue that Tanzania is an exception due to the long history of their primary care services. However, Joseph Asare and Lynn Jones from the non-governmental organisation International Medical Corps shared their experiences with setting up mental health services in war-stricken Sierra Leone, one of the most impoverished

countries in Africa. With a clear policy direction, the political will of the authorities, and some basic resources (simple psychotropic drugs, experienced trainers and a good monitoring system) it proved possible to establish community based mental health care integrated within existing structures. This is a good reason for optimism, if it can be done in Sierra Leone, it can be done anywhere!

So why is it not done? The reason, I believe, is that many donors and policy makers are not convinced that mental health care is worth the investment. It is our task as mental health professionals to provide the kind of 'hard evidence' that is used to 'legitimize' other health interventions (for example in the field of mother and child health care or infectious diseases). Slowly, data are emerging that show how mental health problems have a direct impact on health and poverty, and further, that mental health treatment helps to break the vicious circle of poverty and underdevelopment. At this conference some exciting examples were given of such research. In an elegant study, Abiodun Adewuya compared Nigerian mothers who had post partum depression with non-depressed mothers who were equal on all other parameters. After nine months, the children of depressed mothers had a significantly poorer weight gain compared to children of non-depressed mothers. The depressed mothers were also more likely to have stopped breastfeeding. Also, the infants of depressed mothers were more likely to have episodes of diarrhoea and other childhood illnesses. These findings were corroborated by figures from Malawi presented by Robert Stewart who, in a cross sectional study, found a clear association between the presence of mental health problems in the mother and a low infant height-for-age.

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These studies make the case strongly for inclusion of maternal depression within existing maternal and infant health care policies, and will help to persuade donors and policy makers that investing in mental

health care is not a ‘luxury’, but a bare necessity.

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