

Integrating mental health into primary care in Africa: the case of Equatorial Guinea

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The Spanish Cooperation, through the nongovernmental organisation Sanitary Religious Federation and the financing of the Spanish Agency for International Development Cooperation conducted an assessment of the mental health care system in Equatorial Guinea in 2009. There was no specific mental health policy in place, and no formalised mental health care system. A National Mental Health Policy has recently been approved, and an implementation plan was made by the government and nongovernmental organisations. The plan focuses on integration of mental health into primary care, through capacity building and sensitisation. The implementation is still in the initial phase, and the scaling up process is expected to be slow.

Keywords: Equatorial Guinea, integration of mental health into primary care, scaling up mental health systems

Introduction

This article describes the experience of improving mental health services in Equatorial Guinea. Equatorial Guinea has not faced recent violent conflicts, or natural disasters. Nevertheless, the lessons learned in this process could be of interest in other, emergency contexts in Sub Saharan Africa. The Spanish Cooperation provided the first step of implementation of mental health services in 2009. The main actors involved in the process were the nongovernmental organisation (NGO) Sanitary Religious

Federation (FRS, Federación de Religiosos Sanitarios) with the financing of the Spanish Agency for International Development Cooperation (AECID, Agencia Española de Cooperación Internacional para el Desarrollo).

The FRS has cooperated in the country since 1979, focusing on health services implementation, and since 2003, mainly in the primary care system. The AECID, which manages and coordinates the Spanish Government budget earmarked for development cooperation (AECID, 19/10/2011), used the grant to NGOs as the main development assistance channel in Equatorial Guinea. In 2008, FRS and AECID strengthened an agreement to support the primary health care system to provide an opportunity for the stabilisation of development programmes.

Health professionals in the primary health care increasingly realised the growing need to treat people with mental disorders, while also recognising the insufficient resources to provide this service. In this context in July 2009 the Spanish Cooperation, through the FRS/AECID agreement, conducted the first situation analysis.

In this article, the authors present the main findings of the situation analysis, as well as the achievements and activities leading to implementation of a mental health policy.

The challenge of mental health in Africa

Neuropsychiatric disorders comprise 10% of the burden of disease in Africa (WHO, 2008). Mental disorders are also associated with poverty, marginalisation and social disadvantage. It is also an essential and inseparable component of health, as per the *Lancet* series on global mental health (Prince et al., 2007), as it interacts with other health conditions, such as cardiovascular disease, diabetes, HIV/AIDS or malaria. These are of great concern in Equatorial Guinea, as in other countries of sub-Saharan Africa.

However, because of the high rates of mortality from infections and malnutrition, mental disorders often receive little attention from governments, and are still at the bottom of the list of health priorities for policymakers (Desjarlais, 1995). There is no reference to a mental health care system in Equatorial Guinea in the published literature, the majority of studies of the African Region being from South Africa (Hanlon, Wondimagegn, & Alem, 2010).

The World Health Organization (WHO) emphasises in its *Regional Strategy for Mental Health in Africa* (2000) that mental disease is a major cause of disability, and furthermore, one of the principal problems in tackling this problem is the lack of reliable information systems in the majority of countries (Okasha, 2002).

Equatorial Guinea: the context

Equatorial Guinea is small country in West Africa, with a population of 659,000 people. It is composed of a mainland and five inhabited islands. The dominant ethnic group are the Fang. Other ethnic groups include the Bubi, primarily on the island of Bioco, Annobonenses from the island of Anobón, the Ndowe and the Bisios. The

official languages of the country are Spanish and French, and the other spoken languages are Fang, Bubi, Ibo, and Pidgin.

The country, a former Spanish colony, has been independent since 1968. In its first decade of independence, the country saw severe ethnic violence, in which thousands were killed and around of a third of the population fled to neighbouring countries. Since 1979, after a military coup, the country has been ruled by the same president. Although nominally a constitutional democracy since 1991, the 1996, 2002, and 2009 presidential elections, as well as the 1999, 2004, and 2008 legislative elections, were widely seen as flawed. The president exerts almost total control over the political system and has discouraged political opposition (BBC News 06/10/2011).

Around 61% of the population lives in rural areas (WHO, 2009). There was a strong migratory movement from the middle of the 1990s, with the start of the exportation of oil. The country is currently one of the biggest oil producers in Sub-Saharan Africa. Equatorial Guinea is a middle income country, and ranks 127, from a total of 177 countries, in the Human Development Index (United Nations Development Programme, 2007). The Gross Domestic Product (GDP) is characterised by sustainable development during recent years, from US \$ 73.5 million in 1991 to US \$ 2,188.3 in 2002 (World Bank, 2009). Yet, the total expenditure on health as a percentage of the GDP is 2.1% (WHO, 2006).

There are three doctors and five nurses for every 10,000 inhabitants. The health resources are widely centralised, in spite of political attempts to decentralise, (a law on the transfer of service provision to municipalities was approved in 2003). More than two thirds of all professionals are clinical assistants. Only 14% are nurses, and 1%

midwives. Ten percent of the health care staff are doctors, most of them are foreigners, and 76% of them are based in the major cities, Malabo and Bata, where 39% of the population lives (Ministerio de Sanidad y Bienestar Social & Agencia Española de Cooperación Internacional para el Desarrollo, 2002).

There are two regional hospitals in Malabo and Bata, five provincial hospitals in the provincial capitals, 11 district hospitals in the district capitals, 35 health centres and 291 health posts. The Cuban cooperation, which provides international medical assistance to countries affected by natural disasters or armed conflicts since 1963, contributed a Medical Brigade to the country from 2000, composed of 154 doctors spread over 18 districts, and rotate them every two years. In 2003, Cuba supported mainly hospital care, while the Spanish focused efforts more towards primary health care. With regard to the centres and posts that are not supported by the Spanish Cooperation, the majority are not currently operating, despite the existence of infrastructures. This is due to a lack of human and financial resources, as well as low community participation and management issues.

Traditional medicine

The government recognises the practice of traditional medicine, but it is not widely integrated into the health care system, and there is no regulation of their products (WHO, 2002). The country has a legal framework for traditional medicine, an agency of management and national coordination, an association of traditional medical assistants and a general board of directors of medical assistants. No schools exist, but families pass knowledge from generation to generation, or rely on people with *charisma* and/or leadership capacity.

One main factor contributing to the widespread use of traditional medicine in the country is its accessibility in terms of human and geographic resources, and that it is firmly established in the belief system of the population. In the case of Equatorial Guinea, it does not appear that affordability is a factor because traditional medicine is not necessarily cheap. Costs for treatments can easily mount to approximately 30,000 Fc CFA (US\$65), amounting to 33.3% of the monthly minimum wage.

The healers in Equatorial Guinea can be divided in two groups. On the one hand, there are healers who utilise fundamentally natural methods that generally pass from generation to generation, and are considered by the population to be authentic, *traditional healers*. On the other hand, there are those who practise spiritualist rites and generally attribute their healing powers to supernatural causes, popularly known as *mimbilis*.

Two of the illnesses framed inside the spiritual domain are mental disorders: the Ev⁵ and the Kong. The Ev⁵ is known as the 'seat of secrets and mysterious or extraordinary forces in the Fang man. . . Is to be alive as bacterial or reptilian type that lives in the human womb. It is born within him or can be acquired' (Mbana, 2004). Often when someone is behaving in a strange way, the people around him would say he was possessed by the Ev⁵. The Kong, whose tradition extends to other countries of Sub Saharan Africa such as Cameroon, Gabon and Nigeria, are seen as *'living dead'*, and when a man *'converts'*, he suffers an extensive range of symptoms, such as nightmares, psychic problems, agitation and violence, frequent crisis of epilepsy, movements of the limbs, palpitations, fear and anguish.

Mental illness is popularly known as *'dementia'*, which does not correspond to the meaning of *dementia* in international

classifications. Often the *'dementia'*, is identified by the Fang as *'a poor state of mind'*. It is situated in the heart, rather than in the head: by referring to *'dementia'* the Fang say *akoan nmem*, meaning someone is ill or sick at heart (will), and not *akoan nlo*, meaning to be ill in the head, that only signifies headache in the physiological sense (Mbaná, 2004).

Little is known about the way patients are treated when they arrive at a healing centre, and probably the process differs widely between healers. According to interviews with local health professionals, in the first instance it is often the family of the patient who seeks the services of a healer. Healers do not reveal information about the substances they use to treat patients, however, it is known that containment methods, such as chains or ropes, which are applied in cases of agitation, do not meet basic security criteria.

The mental health system: situation analysis

In July 2009, the Spanish Cooperation conducted a situation analysis in order to strengthen the mental health care system in the country (Morón-Nozaleda & Fernandez-Liria, 2009). Prior to fieldwork, a survey was conducted among the seven teams from primary health care and the 17 health centres supported by the Spanish cooperation. The survey consisted of 19 items, covering these five topics: 1) the demand in mental health care from primary care; 2) attention for mental healthcare from primary care providers; 3) the attitude towards the mentally ill; 4) access to psychotropic medicine and; 5) attitude towards further training in mental health care. The participation rate was only 31%, so no meaningful conclusions can be drawn from this survey. In regard to the low participation rate, it related almost entirely to not answering due to the *'lack of*

familiarity with mental health care and lack of coverage in that area'. The only exception to this was one of the centres.

As a guide for the fieldwork, the WHO *Assessment Instrument for Mental Health System Tool* (WHO – AIMS) (WHO, 2005) was used to collect the principal information. The methods of data collection were mainly qualitative. Semi-structured interviews were conducted with all team coordinators and health professionals, from a total of 15 primary health care teams, throughout the country. The researchers spent at least one day with each team, participating in the doctor/patient encounter and home visits to users and their families. Two focus groups were carried out, one with school teachers, to explore mental health care in children and adolescents, and one with women to explore mental health care in that target group. Although it was planned to conduct a group of users and their families, it was not possible for geographical reasons. There was also no possibility of access to prisons and the legal system. In depth interviews were conducted with policymakers, national health coordinators, representatives of the Cuban cooperation, and the two psychiatrists working in the country.

The main findings of the assessment are summarised in Table 1.

Burden of mental disorders and treatment gap

In the health centres where neuropsychiatric treatment is offered, mainly in Bata, Malabo and Ebebiyin, mental health consultations in 2008 accounted for 11% of total consultations, 47% were women and 53% men. Fifty five percent of the consultations were for people between 15 and 44. The most prevalent pathologies are epilepsy (32% of cases in 2008 in the coastal region) and schizophrenia (21%). There is great concern about alcohol abuse, as well as other drugs

Table 1. Situation Analysis

Situation analysis (July 2009)	
<i>Policy and legislative framework</i>	No mental health policy or strategic plan. Specific programme for alcoholism (in draft). Plan from the Ministry of Health on building two neuropsychiatric hospitals of 50 beds each (expected in medium to long term). No specific legislation. No specific financial resources have been allocated to mental health care. The budget for the construction of the neuropsychiatric hospitals remains unclear. Financial funding for physical disability and intellectual disabilities (still in survey phase).
<i>Organisation of mental health services</i>	No specific mental health services exist in the country. The two psychiatrists from the Cuban cooperation attend an outpatient practice in the hospitals of Bata and Malabo, and a health centre in Bata. No beds are available for neuropsychiatric patients in hospitals. There are Spanish nurses who attend neuropsychiatric patients in primary health centres, mainly in the one located in Ebebiyin, with a bed for acute inpatients. Traditional medicine is widely distributed throughout the country, and the perception of primary health care workers is that the mentally ill first seek treatment through traditional medicine.
<i>Availability of essential psychotropic medicine</i>	Only diazepam, phenobarbital and phenytoin are available at all levels, however, distribution is irregular. Availability of psychotropic medication (more than one kind of antipsychotics, typical and atypical, and antidepressants) in four health centres, obtained through cooperation, with large variability in stock.
<i>Human resources</i>	No Equatorial Guinean psychiatrists. There are two Cuban psychiatrists attending the General Hospital of Malabo and Bata, and surrounding primary care centres. One Equatorial Guinean psychologist attends the psychosocial programme for HIV/AIDS patients.
<i>Training, support and supervision</i>	No mental health care nurses. There is a medical faculty in the country. The specific training on mental health is 2,4%. No mental health training is provided in the nurses' training. There is no faculty of psychology (to come).
<i>Monitoring</i>	The health information system is distributed to all the hospitals and health centres, and supposed to be collected monthly at regional level. This is not actually collected on a regular basis, is not reliable and the rate of response is low. It includes an item about psychiatric consultants, but this is not usually reported.

obtained from the jungle: *banga* (marihuana), *eboga* and *ondin* (hallucinogen) and *mocuba* (stimulation). Incidence of suicide is not registered.

According to the data from the *World Mental Health Survey* (2004), it is estimated that in the continental region of the country 15,000 people (3%) would suffer from a severe mental disorder and around 49,000 (10%) from a mild to moderate mental disorder. Therefore, there is an enormous gap in treatment (98.5%), since just 896 patients received treatment, in the whole coastal area, during 2008.

The scaling up process

Towards a mental health policy

In 2009 and 2010, several consultations were conducted by the Ministry of Health in order to reach a consensus on the next steps in the implementation of mental health services in the country. Owing to the high commitment of the government, as a first step the Ministry appointed a Mental Health Responsible. After a workshop in May 2010, with the participation of representatives from the Ministry of Health, WHO, Cuban and Spanish cooperation, and professionals in the general health system, a first draft of the Mental Health Policy was presented and circulated for consultation, before being finally approved on November 2010. The policy is intended to be an instrument to guide the whole implementation plan, and its main goals are:

1. Promote legislative changes needed to achieve full integration of mental health care at different levels of care.
2. Define and implement a specific training plan on mental health care for each professional profile involved.
3. Ensure access to essential psychopharmacology, reducing the gap in treatment.
4. Reduce stigma and discrimination of mental illness among the general population and professionals, with development of awareness raising campaigns.
5. Improve the prevention of severe mental disorder and substances abuse, including early intervention and reduction of risk factors.
6. Define and implement a framework of coordination among all implicated sectors.

These goals aim to follow the international recommendations for mental health policy development in Africa (Gureje & Alem, 2000). The next step is to get approval for the strategic plan, with clear strategies and phases. Health staff and authorities have already designed a first draft. Without appropriate dissemination and operationalisation of the policy, its implementation is at risk of becoming weak and poor, as found in other countries such as Ghana or Zambia (Omar et al., 2010).

Integrating mental health care into primary care

Parallel with the policy development, from June 2010 the aspects of the project financed by the Spanish cooperation have focused on primary health care.

Primary care affords a better chance to promote accessibility and affordability, community awareness, and to coordinate with the traditional system (WHO & Wonca, 2008) (WHO, 2001). Obstacles and challenges are very similar to those in other low to medium income settings, guiding our efforts in relation to the WHO and World Psychiatric Association (WPA) recommendations (Thornicroft et al., 2010).

Few people suffering from a mental disorder, or their families, seek aid. In cases when they do, care delivery usually comes from traditional healers first. In these cases,

sometimes medical condition may worsen, and the dignity of the patient cannot be guaranteed (owing to use of restrictive and uncontrolled methods, such as chains and ropes). This pathway to care seems to be similar to other African countries, such as Uganda (Ssebunnya et al., 2010) and Nigeria, where the mental health care system is well documented (Eaton & Agomoh, 2008).

The main obstacles and achievements are summarised in Table 2. Data have been obtained from an update of the situation analysis, conducted in July 2009, and the consensus of the workshop held with all stakeholders in May 2010.

The main opportunities for integration are the health professionals' availability and interest, professionals in the FRS with special concern for mental health disorders and experience in the field, and the growing awareness and interest of the government.

The activities implemented at the moment are based mainly on capacity building and awareness raising campaigns. In September and October 2010, the Spanish offered specific courses to health agents, auxiliaries and nurses, which will be repeated on a cyclical basis. Health agents have undertaken training in sensitisation, case finding and referral to health centres. On the primary health care level, the staff is receiving training on the basis of diagnosis and treatment, as well as referral criteria to a specialist. Specialist professionals are developing clinical guides and protocols for every level of care, on the basis of evidence based packages of care, relevant in the literature (Patel & Thornicroft, 2009; WHO, 2010).

The Spanish cooperation sponsored a specialised outpatient facility at the end of 2010, where expatriate mental health nurses, belonging to the FRS, lead. The headquarters is in Bata, and it has rehabilitation

places. Trainer training courses are available in order to guarantee training and supervision in primary care, as well as clinical rotations of auxiliaries and nurses at the primary level.

Awareness raising campaigns are also taking place through radio programmes and vignettes representing the major mental disorders (schizophrenia, acute psychosis, mania, and depression), as well as covering alcohol abuse in schools and health centres. Child and adolescent advocacy is a great challenge in the medium term, especially in rural areas.

A regular back-up in terms of supervision by the most experienced health centres of other primary care settings is under way, although there is an absolute paucity of local specialists, and this needs a long term solution. The regular supply of essential psychotropic medication is another major challenge, as at the moment NGOs are the only supplier. Both of these issues are crucial to the sustainability and success of the implementation model (Hanlon et al., 2010).

Case finding and detection programmes are developing as the cornerstone of the interventions. One of the main concerns is the survival of severely mentally ill people, living in the large urban areas after expulsion from their own communities. Specific programmes must be available, such as assertive community treatment teams and community based residential care. The goal of developing community mental health services is to give people equitable access in the '*least restrictive environment*', and involve users and families in the process (Thornicroft et al., 2010).

Conclusions and future directions

The mental health system in Equatorial Guinea is in its very early stages. The greatest

Table 2 Obstacles and achievements

Obstacles	Achievements and goals
No mental health policy, plans or programmes.	The first mental health policy was approved in November 2010. The Strategic Plan is in the approval and development phase.
Lack of training among general health professionals. Overwhelming the primary care system.	First specific training programmes for every level of care conducted. Clinical guides and protocols developed. Supervision and monitoring by more experienced professionals in primary health care in order to help them with care of neuropsychiatric patients.
Paucity of specialised mental health professionals.	Recruitment and training of specialised professionals: short term training courses; clinical rotations in foreign countries; long term specialist training.
Care delivery for neuropsychiatric patients is available in only four centres in the country.	Mental health integrated in general health care. Supervision from the specialised level. Case finding and detection in the community, through health worker training, mobile teams and coordination with the traditional medical practitioners and schools. Monitoring of chronic patients within the community.
No acute wards or any in-patient resources.	In the medium term, beds in district hospitals may be available for acute patients. Neuropsychiatric hospitals as reference system; in-patients admitted for short-term treatment and supervision of the community based monitoring.
Lack of legislation; stigma and discrimination; lack of effective advocacy.	Need to strengthen the protection of the human rights of people with mental disorders or illness, and their families, already one of the main goals of the policy. Development of specific legislation. Promotion of users and family associations.
Lack of awareness in the community. No prevention or promotion programmes.	Awareness campaigns through mass media and health education programmes at schools and in villages. Early detection of patients in the communities. Specific programmes for the prevention of alcohol and other substance abuse.
Widespread use of traditional medicine in the case of mental health conditions. Quality of care and respect of human rights are rarely guaranteed.	Coordination with traditional healers and integration in the training and awareness activities.
Distribution of essential psychotropic medication is irregular and scarce.	Essential psychotropic medication must be included in the essential medication list of the country, and government must guarantee the supply. Availability must be well defined for every level of care and professionals adequately trained.

Table 2 (Continued)

Obstacles	Achievements and goals
No public financing for mental health programmes.	Government must guarantee basic resources such as essential psychotropic medication supply. Budget must be decentralised.
The health information system is ineffective.	Basic mental health indicators must be collected (case detection and monitoring of chronic patients, availability of psychotropic medication, hospital indicators) and professionals must be trained in these issues. Prevalence research must be conducted at a national level.

challenges at the moment are the operationalisation of the mental health policy through an adequate strategic plan, and the development of specific programmes for the most vulnerable populations, such as children, adolescents and people suffering from severe mental disorders. Positive factors could be the established primary health care system, government commitment and the relative small size of the country. On the other hand, the neuropsychiatric hospitals due for construction by the government must guarantee a community care approach, which is not yet insured, and can suppose a risk of institutionalisation.

Close monitoring and regular evaluation of the implemented programmes must be a priority, in accordance with the international recommendations on scaling up mental health systems in low and middle income countries (Thornicroft et al., 2010), as well as the accumulated local experience.

Conflicts of interest

No conflict of interest.

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