MENTAL HEALTH PLANNING IN AFRICA :

Issues and Strategy

By

Olayiwola A. ERINOSHO *

INTRODUCTION

Development for African countries is usually construed in terms of a high standard of living, rapid industrialization, including the availability of vital facilities and personnel such as schools, hospitals, and experts in various fields. More often, development is perceived by responsible authorities in Africa as a blind imitation of the technologically advanced Euro-american societies. Yet many of these countries lack the resources needed for attaining the current Euro-american stage of development in the next two or three decades.

This observation is also especially valid in the context of mental health planning in Africa because this region of the world is indeed open to the temptation of want only embracing the ideology, as well as the current mental health therapeutic framework of the technologically developed societies.

It is the aim of this paper to delineate and examine some central issues in mental health planning in developing African countries. More important, the paper highlights the overall importance of some approaches vis-à-vis other widely recognized ones in the formulation of meaningful, and socially relevant mental health policy in Africa.

The broad emphasis on Africa rather than on a particular country derives on the ground that despite regional variation in terms of specific needs, some common mental health problems are clearly self-evident in the continent. The conceptual rationale for the approaches that are suggested for Africa in this paper stems from the recognition of these common mental health problems which are also fully discussed in the following section.

ISSUES IN MENTAL HEALTH PLANNING

Some of the issues in mental health planning can be examined within the context of three major typological dimensions. The dimensions revolve around: (i) hospital-centred delivery-system versus a

---

* *Ph.D., Department of Sociology, University of Ibadan, Ibadan, Nigeria.*

community-oriented focus, (ii) a culture-bound versus a non-culture bound conceptual therapeutic orientation; and (iii) preventive as opposed to curative psychiatric program.

Hospital-centred versus community-oriented model of care.

Should Africa opt for a strictly hospital-centred therapeutic model, or a community-oriented approach in the development of a comprehensive mental health delivery-system? The answer to this fundamental question lies partly in a clear-cut explication of the structural attributes and normative basis of these models of care, as well as in a brief review of the merits and/or demerits of each approach vis-à-vis the existing conditions in Africa.

First, these two therapeutic models of care can be viewed as typological constructs in any analysis of psychiatric rehabilitation since they do not really exist *in toto* as they are presently characterized. These ideal types therefore presuppose the existence of other kinds of therapeutic structures or orientations which can conveniently be placed within the two polar types (1).

The hospital-centred (2) or custodial psychiatric system is characterized by its authoritarian structure and disruptive institutional boundaries. The custodial care is rooted in certain manifest and latent goals. First, custodial care is manifestly aimed at restoring the mental health of psychiatric patients. In the process of pursuing this objective the patient undergoes resocialization into the «sick role». Second, significant others are seldom or never directly involved in the rehabilitation process. Third, there is often a marked and definable transition for the patient as he moves from the hospital to the community or his family.

The hospital-centred or custodial therapeutic approach usually requires the availability of enormous resources. By resources we mean adequate formally trained psychiatrists, registered psychiatric nurses, social workers, occupational therapists and a variety of other attendants Hospital-centred approach also presupposes the provision of concrete facilities (e.g., buildings, beds, etc.,) whose overall cost cannot be readily and easily computed in this discussion. In addition, substantial funds are needed for implementing as well as maintaining a comprehensive mental health program which is firmly based in a hospital-centred psychiatric approach.

In contrast, a community-oriented psychiatric system is held to be informal and diffuse. It is intended to be non-authoritarian because a patient's significant others are involved in the rehabilitation process. It differs from a dyatic setting which consists of patients who are expected to follow a regimen, and staff members who exercise medical and social authority. The setting is modelled along a patient's normal social patterns because of the diverse principal actors involved in the rehabilitative process.

Available evidence suggest that a community-oriented psychiatric program has some socio-economic and therapeutic benefits. The frequently reported assets of the community-oriented model are : (a) the fact that this therapeutic approach emphasizes the role of middle cadre professional psychiatric personnel who can be trained more easily and at less cost than psychiatrists; (b) the reduced cost for care due to the relative absence of a range of facilities and personnel usually needed for a hospital-centred care; and (c) the possibility of hightening community tolerance toward mentally ill persons through the involvement of next of kin and significant others during the therapeutic process (Lambo, 1964; 1968). In actual fact, it has been argued that the latter could enhance the treatment outcomes of mentally ill persons since the stigma which is often associated with psychiatric disorder by the public could be minimized.

Today, formally trained mental health workers including psychiatric facilities are lacking in many parts of Africa. For instance, Harding's (1976) recent survey of some African countries highlight the apparent scarcity of psychiatrists. In this respect, (See Table I), there are 103 psychiatrists in nine African countries whose overall population is close to 94.3 million. The table clearly reveals that there is one psychiatrist to 915,243 persons.

The same picture is probably self-evident in respect of other professional mental health workers such as psychiatric nurses,social workers, occupational therapists and others whose figures have not been fully reported upon in available literature.

The scarcity of vital mental health workers and of psychiatrists in particular is likely to persist partly because African countries lack the resources needed for the training of a large number of professional care agents. In addition, it has become necessary to give low priority to mental health problems and care because African countries currently face the more serious health task of combating and eradicating fatal parasitic and infectious diseases.

The fact that the shortage of psychiatric workers and facilities will remain in Africa is by itself a stimulus for the search for an alternative strategy to mental health care, albeit, a strategy which would facilitate the optimum utilization of available resources. It is in this respect that a realistic answer lies in a community-oriented rather than in a hospital-centred or custodial therapeutic focus.

Developing countries in Africa need not look beyond the boundary of the continent in order to concretize the proposal for a community-oriented psychiatric program. More than two decades ago, a leading African psychiatrist initiated a community-oriented psychiatric program in Nigeria (Lambo, 1964; 1968). This experiment which is known as the Aro Community Village Program in Community Psychiatry is grafted in the middle of a village, and serves the surrounding catchment area of

Table I – *Psychiatrists working in some African countries.* (3)

Country	Number of Psychiatrists	Estimated Population	Ratio
Ghana	10	9,900,000*	1 : 990,000
Ivory Coast	7	4,900,000*	1 : 700,000
Liberia	1	1,800,000*	1 : 1,800,000
Mauritania	22	1,300,000*	1 : 59,091
Mauritius	8	900,000*	1 : 112,500
Nigeria	30	55,070,000**	1 : 1,835,667
Reunion	7	500,000*	1 : 71,429
Sudan	17	17,700,000*	1 : 1,041,176
Togo	1	2,200,000*	1 : 2,200,000
Total	103	94,270,000	1 : 915,243

* 1975 population estimate.
** 1963 population estimate.

(3) *Information on the number of psychiatrists has been abstracted from «Mental Health Research in Africa», by T. W. Harding, a paper presented at the Workshop on Mental Health Services and Research Strategy, Lusaka, Zambia, September, 1976.*

several village communities. It is a day care center which stresses the involvement of next of kin and significant others in the therapeutic process. Furthermore, the program has been feasible because of the emphasis which is placed on the role of a few professionally trained middle cadre workers such as nurses and attendants.

Experience over the years has shown that a range of patients with various types of disorder amongst whom are severely disturbed psychiatic cases could be treated in this center. The village experiment has also attracted literate and non-literate, patients from various parts of the country. Furthermore, the cost of providing care through this experiment has been substantially reduced simply because the facility does assume responsibilities on matters relating to accommodation, meals and a large attendant staff. Above all, the program has made it possible for a few formally trained workers to be accessible to a large catchment area. (Erinosho, 1977).

Culture-bound versus Non-culture bound.

The second issue for consideration is in relation to the most appropriate ideological framework for mental health care in Africa. In short, should therapy be culture-bound or non-culture bound?.

In a previous discussion, Erinosho (1976) observed that «a culture-bound conceptual orientation to mental health care» emphasizes a convergence of healing methods through the joint role of native healers and western-oriented psychiatrists or their treatment techniques, whereas the non-culture bound clearly recognizes but does not accept *in toto* the overall importance of traditional healing methods or the role of native healers in the modern therapeutic process.

The relevance of a conceptual orientation to mental health planning in Africa cannot be underestimated because various studies indicate that the widely held concept and etiology of mental illness among many Africans is still profoundly rooted in socio-cultural factors such as the evil machination of the enemy through witchcraft, strain in interpersonal social relations and cosmic forces (Lambo, 1955; Field, 1960; Baasher, 1961). Furthermore, many persons tend to seek care from assorted native healers rather than from the modern psychiatric hospitals at the onset of illness partly because of the widely held concept of illness, and due to the fact that they (i.e., the mentally ill) probably have greater confidence in the therapeutic skills of the traditional healers than in the formally trained psychiatrists.

This aspect of illness behaviour among the mentally ill in Africa has caused Lambo (1959) to remark several years ago that «our observation in Africa would seem to show that indigenous African cultures have not accepted European methods of treatment in their present forms and our people seek medical care with a considerable degree of

ambivalence, but paradoxically, with such a degree of dependence, and often despair resignation, that increases both effectiveness and difficulties of the physician to the point where he may earn undue credit or undue blame».

This reality has stimulated the debate on the most appropriate and relevant therapeutic approach for non-literate developing societies. There are on the one hand those who object to the integration of traditional healers or healing methods into modern health care on the ground that (i) not enough is known about the healers and their therapeutic methods to warrant integration; (ii) traditional healing lacks a systematically organized body of knowledge; (iii) has no proven and universally established or recognized standards for dispensing medication; or (iv) that the integration of traditional healing into modern psychiatric therapeutic process would pose more complex problems than if it were treated with benign neglect until it eventually disappears. For them the issue is not really the accommodation of the magico-religious belief-system or dependence on assorted traditional healers, but the urgent need for mass health education, and the availability of services and personnel. (Asuni, 1974).

Some others recognize, and stress the convergence of traditional methods through the role of native healers and western-oriented psychiatrists or their techniques in the therapeutic process. This school contends that (a) because of the scarcity of formally trained medical personnel in Africa, and due to the large number of available traditional healers, the latter could probably be used as alternative health care agent; (b) that it might be unrealistic to think that the effectiveness of mental health care workers and services can be enhanced unless the belief system of the people can somehow be accommodated within the framework of the modern therapeutic process; (c) that some of the herbs and medicinal plants such as rauwolfia which native healers use are pharmacologically active and potent and (d) that available data do not suggest that many would repudiate the magico-religious notion of illness with increasing modernization (Ademuwagun, 1969; Harrison, 1974; Erinosho, forthcoming).

It is certain that the debate on the relevance or irrelevance of traditional healing methods and healers as well as the widely held concept of illness to modern mental health care in Africa will persist for some time to come. In the meantime however, Africa could simultaneously pursue the following goals. First, the curriculum for medical education may be structured and organized in such a way that trained physicians and paramedical can understand the full scope, and perhaps accommodate the widely held belief-system. Second, research into native healing methods particularly within the context of types of illness or patients for whom they are most effective as well as the pharmacological content of medicinal plants and herbs is urgently needed. The former objective

could enhance communication between physicians and patients and this can in turn improve the effectiveness of modern health workers and services. On the other hand, the latter could eventually yield the necessary baseline information for integrating some traditional therapeutic regimen into the modern mental health care.

Preventive versus Curative psychiatric program.

It is partly logical to assert on the basis of our discussion so far that Africa ought to emphasize the preventive of mental illness rather than hope to implement an effective and comprehensive curative program which requires tremendous resources. Preventive psychiatry is defined in this context as «a program for reducing (i) the incidence of mental disorders of all types in the community; (ii) the duration of significant number of those disorders which do occur and (iii) the impairment which may result from those disorders», (Caplan, 1964). But all of these may be accomplished through mass mental health education for members of the community.

Africa is now undergoing rapid social change. Reports from various studies suggest that some of the underlined social consequences of industrialization, and which are presently being manifested in Africa include the breakdown of the extended family which has always provided social security for the average person, the rise in the incidence of juvenile delinquency and violence, social stress and unrest, unemployment or underemployment and so forth. Hitherto, Leighton et al., (1963 a, 1963 b) asserted that such social consequences of industrialization which are symptomatic of social disorganization, tend to induce a profound degree of psychopathology.

Perhaps, a mental health education program of industrializing African societies could highten the level of awareness on the forces which can induce mental illness, and on the behaviourial aberration that are symptomatic of illness. Mass mental health education can also enhance early referral to the appropriate psychiatric delivery-system or agent. Although early referral can in turn improve prognosis and care for the mentally ill persons, yet it seems that all of these might well depend on the availability and accessibility of psychiatric service to a substantial number of persons in Africa.

NOTES

(1). These models are viewed as polar ideal types because we recognize the proliferation of other approaches to mental health care. For example, there are those which are labelled as: «open hospitals», «sheltered workshops», «half-way Houses», «crises centers» «day and night hospital» and so forth.

(2). Much of the characterization of the two models arise from a close review of works which deal with prototypic models of these approaches to mental health care. In this respect, hospital-centred approach is more or less liken to a «total institution» as described by Eriving Goffman (viz., Asylum, Doubleday Anchor, New York, 1961).

REFERENCES

Ademuwagun, Z.A. (1969) «The Relevance of Yoruba Medicine men in Public Health Practice», *Public Health Reports*, U.S. Department of H.E.W., Vol. 84.

Asuni, T. (1974) Personal Communication.

Baasher, T.A. (1961) «Observations from Sudan» in T.A. Lambo (ed), *First Pan-African Psychiatric Conference, Abeokuta, Nigeria*, Ibadan: Government Printer, Western Nigeria.

Caplan, G. (1964) *Principles of Preventive Psychiatry*, London: Tavistock Publication.

Erinosho, O.A. (1976) «Evolution of Modern Psychiatric Care in Nigeria», *Africa Development*, Vol.1, No.3.

Erinosho, O.A. (1977) «Mental Health Delivery-systems and post-treatment performance in Nigeria», *Acta Psychiatr. Scand.* 55.

Erinosho, O.A. (Forthcoming) «Belief-system and the concept of mental illness among medical students in a developing African country: A Nigerian Example», *Journal of Anthropological Research* Summer, 1977.

Field, M.J. (1960) *Search for Security* – An ethnopsychiatric study of rural Ghana, London: Faber and Faber.

Harding, T.W. (1976) «Mental Health Research in Africa,» a paper presented at the Workshop on Mental Health Services and Research Strategy, Lusaka, Zambia, September, 1976.

Harrison, Ira. E. (1974) «Traditional Healers: A Neglected Source of Health Manpower in Newly Independent Countries, «*Journal of Health Society, Nigeria*, Vol. XIX, No.1

Lambo, T.A. (1959) «Mental Health in Nigeria – Research and its Technical Problems.» *World Mental Health*, 11

Lambo, T.A. (1955) «The Role of Cultural Factors in Paranoid Psychoses Among the Yoruba Tribe.» *Journal of Mental Science*, 101

Lambo, T.A. (1964) «Patterns of Psychiatric Care in Developing African Countries.» In Ari Kiev (ed.) *Magic Faith and Healing*, London: Macmillan Ltd.

Lambo, T.A. (1968) «Experience with a program in Nigeria.» In R.Williams and L. Ozarin (eds.) *Community Mental Health: An International Perspective*, San Francisco: Jossey-Bass Inc.

REFERENCES (cntd.)

Leighton, D.C., J.S. Harding, D.B.Macklin, A.M. Macmillan, and A.H. Leighton (1963a) *The Character of Danger. New York. Basic Books.*

Leighton, A.H., T.A. Lambo., C.C. Hughes, D.C. Leighton, J.M. Murphy and D.B. Macklin (1963b) *Psychiatric Disorder Among the Yoruba* – A Report from Cornell-Aro Mental Health Research Project in the Western Region, Nigeria, Ithaca: Cornell University Press.

RESUME

Dans l'article qui précède, l'auteur étudie l'important problème de la planification en matière de santé mentale en Afrique. Son but est de nous montrer que la planification en matière de santé mentale telle qu'elle est conçue dans les pays développés Européens et Américains n'est pas la seule voie qui peut nous garantir une réussite dans ce domaine.

Il introduit son sujet en faisant remarquer que le véritable frein au développement de l'Afrique est que le développement y est conçu comme une immitation aveugle des sociétés technologiquement avancées alors que les pays Africains ne disposent pas des ressources nécessaires capables de produire un tel développement. Dans le cas précis de la planification en matière de santé mentale, l'Afrique a cédé à la tentation plus facile d'adopter l'idéologie et les principes thérapeutiques des maladies mentales des pays développés Européens. Son analyse s'articule en trois points principaux :

Dans une première partie, il compare les formes de traitement des malades mentaux basés sur l'internement de ces derniers dans un hôpital et celles qui les maintiennent dans leur communauté.

La deuxième partie est consacrée à la comparaison des formes de traitement qui les coupent de leur environnement culturel à celles qui se font dans cet environnement culturel.

Dans la troisième partie, il suggère une stratégie pour prévenir les maladies mentales.

I.– *L'Hôpital ou la Communauté comme lieu de traitement*

Notre choix pour l'un ou l'autre lieu de traitement doit être déterminé non seulement par la structure et les normes de ces deux lieux de traitement mais aussi par les avantages et les inconvénients de chacun de ces deux lieux de traitement compte tenu de la spécificité de l'Afrique.

La forme de traitement qui fait de l'hôpital l'unique lieu de traitement se caractérise par sa structure autoritaire et son aspect disruptif. En effet le malade mental y est séparé des siens et sa réintégration dans

sa communauté d'origine s'y fait sans aucune phase de transition. Cette forme thérapeutique nécessite aussi beaucoup de ressources tant du point de vue de l'infrastructure (bâtiments, lits etc...) que du point de vue des ressources humaines (personnels).

Au contraire dans le cas du système de traitement des malades mentaux basés sur la communauté, le malade est traité dans son milieu de tous les jours. C'est donc un système non autoritaire qui implique la présence des parents du patient dans le processus de réintégration.

II.– *Thérapeutique liée ou non à l'environnement culturel*

Pour l'auteur, les méthodes thérapeutiques du traitement des malades mentaux devraient dans une large mesure tenir compte de l'environnement culturel dans lequel ils baignent, ne serait-ce que parceque de nombreux travaux de recherche ont indiqué qu'en Afrique les causes des maladies mentales sont encore souvent attribuées à des facteurs socio-culturels comme la sorcellerie, les forces cosmiques et les tensions dans les relations individuelles entre les personnes. Les raisons avancées pour la non-utilisation des méthodes thérapeutiques traditionnelles ne sont pas suffisamment convaincante pour exclure la science traditionnelle relative à la thérapeutique des maladies mentales. Pendant que le debat sur ce problème continue, l'Afrique devrait poursuivre les deux objectifs suivants :

– d'abord les programmes des études médicales devraient être aménagés de telle sorte qu'ils puissent rendre compte de l'importance de la question et peut être même contenir ce système de croyance largement répandue.

– ensuite une recherche plus poussée devrait être conduite aussi bien que les méthodes curatives que les propriétés pharmacologiques des plantes et des herbes médicinales.

III.– *Programme préventif et programme curatif*

De ce sui précède on peut déduire que l'Afrique devrait chercher à établir des programmes préventifs plutôt que curatifs. Ces programmes préventifs doivent mettre l'accent sur l'élimination des causes socio-économiques des troubles mentaux. L'Afrique est en effet entrain de s'industrialiser et déjà les conséquences se font sentir . Ce sont :

– l'éclatement de la famille élargie
– le développement de la délinquance juvénile et de la violence
– les tensions sociales et les troubles
– le chomâge ou le sous-emploi

Ne sont—ce pas là les symptômes d'une désorganisation de la société, elle-même génératrice d'un profond degré de psychopathologie ?.