Africa

Democratic Republic of Congo

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The delivery of mental healthcare in the Democratic Republic of Congo (DRC), formerly Zaire, is influenced by geography, politics, legislation and the structure of the health system, as well as traditional beliefs and culture.

The DRC is in Central Africa; the Central African Republic and Sudan border to the north, Uganda, Rwanda and Burundi to the east, Zambia and Angola to the south, and the Republic of Congo to the west; and it is separated from Tanzania by Lake Tanganyika to the east. The country occupies 2 345 408 km^2, which is slightly greater than Spain, France, Germany, Sweden and Norway combined. For administrative purposes the country is divided into 11 provinces, each with a provincial headquarters.

The population is over 66 million, with 47% aged under 15 years and 4% over 60. Average life expectancy at birth is 46 years for men and 49 years for women. There are around 350 ethnic groups; the largest groups are the Kongo, Luba and Mongo peoples. There are also around 600 000 Pygmies, the aboriginal people of the DRC. Although some 700 local languages and dialects are spoken, there is widespread use of French (the official language); the most common local languages are Kongo, Tshiluba, Swahili and Lingala. Eighty per cent of the population are Christian, 10% Muslim and 10% follow traditional beliefs or syncretic sects (Central Intelligence Agency, 2008).

Before independence in 1960, the DRC was under Belgian colonial rule. The economy, despite the country's vast natural resources, has greatly declined since the mid-1980s. Recent conflicts, which began in 1996, have dramatically reduced national output and government revenue and increased the external debt, as well as resulting in famine and disease and 5 million conflict-related deaths (US State Department, 2009).

Despite a current lull in overall violence, the plight of people across the eastern DRC remains dire. Thousands have been displaced following renewed violence or rumours of impending violence. Achieving mental health for the population of the DRC is a priority for its economic recovery, achievement of physical health goals and creating resilience among the local people.

Mental health policy and legislation

The DRC's mental health policy was formulated in 1999. Its essential components are advocacy, promotion, prevention, treatment, rehabilitation and education; there is also a substance misuse policy. The national mental health programme was also formulated in 1999 (World Health Organization, 2005). The Ministry of Health is responsible for the organisation, management and planning of mental health sectors, and it is represented at provincial, district and community level.

The DRC has ratified the international legal instruments concerning the rights and protection of people who are mentally ill, but there is as yet no DRC law defining the rights and protection of people with mental illness or regulating the procedures for voluntary or involuntary admission to a psychiatric hospital.

Mental disorders in the DRC

Popular beliefs persist about supernatural causes of disease in general and psychiatric problems in particular (Okitapoy, 1993; Okitapoy *et al*, 1996).

Mental disorders are probably at least as common in the DRC as they are elsewhere, but there are no national epidemiological data. Statistics from two psychiatric centres, the Soins de Sante Mentale (SOSAME) Psychiatric Centre in Bukavu (a post-crisis region) and the Katwambi Centre Neuropsychopathologique (CNPP) (in Kasai province), show the following:

- 80% of patients are under the age of 40, 36% aged 21–30
- there are 1.02 female patients for each male patient
- half the patients are without employment
- 6–15% of patients have schizophrenia
- 6–31% have other psychotic disorders
- 22% suffer from anxiety disorders (related to war trauma for 18%, to sexual abuse for 3.5% and to other factors for the remaining 0.5%)
- 13–23% of patients have mood disorders (manic episodes, depressive disorders and bipolar disorders).

Psychiatric services

Historical background

In 1926, a psychiatric institution situated along the Congo River called Mount Stanley Lazaret was created by order of the colonial authority, and from 1928 was open to patients with mental illness, tuberculosis and leprosy. In 1960, the centre became the Mount Stanley Psychiatric Institute but in 1969 it closed. It was replaced by the CNPP–Mount Amba in 1973, associated with the University of Kinshasa medical faculty. In 1957, the CNPP opened in Katwambi.

Current mental health services

Mental healthcare is delivered by private institutions as well as general and company hospitals. According to the current national health sector plan (Ministère de la Santé, 1999), mental health should be integrated into primary care. The national mental health programme is responsible for carrying out this integration. Under the general health decentralisation policy, it is planned to establish a mental health programme in each province and district, with support for the health zones and basic health units.

However, the mental health infrastructure still remains very centralised in Kinshasa, the capital, and some provinces. There are two university institutions: the CNPP–Mont Amba in Kinshasa and the Department of Neuropsychiatry of Sendwe Hospital in Lubumbashi. There is one state hospital, operated by the Roman Catholic Brothers of Charity (the CNPP–Katwambi). In addition, there are mental health centres, 90% of which are run by Roman Catholic organisations. There are also some private clinics run by Congolese neuropsychiatrists in Kinshasa.

There are no budgetary allocations for mental health. Primary funding comes in the form of out-of-pocket expenditure by the patient or the patient's family. The cost of psychiatric treatment is considered high in relation to average earnings (World Health Organization, 2005).

Mental health workforce

Specialist human resources in mental health are also very centralised. Currently, there are 34 neuropsychiatrists for a population of over 66 million, of whom only 2 are in the provinces – the other 32 are in Kinshasa. Thirteen Congolese neuropsychiatrists are abroad (Belgium, France, Canada, the USA, and South Africa). In addition, four general practitioners have had 6 months' training in neuropsychiatry. There are 0.01 psychologist clinicians and 0.03 psychiatric nurses per 100 000 population, but again they are mainly in Kinshasa. There are no occupational therapists or social workers qualified in mental health (World Health Organization, 2005, 2006).

Education and training

Medical training lasts 7 years and is available at a number of universities, including Kinshasa, Lubumbashi and Kisangani. Specialist training in neuropsychiatry for doctors and nurses is available only at the CNPP, University of Kinshasa, and lasts 5 years. That CNPP is mandated: to provide care to the community; to act as a training centre for mental health professionals at all levels, including academic and scientific personnel working in the field of neurology and psychiatry; and to serve as a biopsychosocial research centre for the University of Kinshasa.

As mental health is being integrated into primary care, regular training of primary care professionals is carried out in the field of mental health.

To facilitate access to mental healthcare despite the shortage of specialists outside Kinshasa, there is a training programme of 6 months in psychiatry (at the Kinshasa CNPP) for general practitioners.

There is no training available for occupational therapy or social work.

The government also partially supports some charitable organisations like SOSAME and some non-governmental organisations that provide mental health services and training (Réseau des ONG d'Action en Santé Mentale, 2007).

Human rights

Human rights violations have been perpetrated by rebels, militiamen and other armed groups. According to Amnesty International (2007), the transitional power-sharing government since 2003 has made little progress in advancing the law and respect that are essential to securing human rights. Meanwhile, the eastern DRC partially remains under the control of some armed groups. Insecurity, unlawful killings, human rights abuses, ethnic tension, widespread rape and sexual exploitation of women and girls, torture and illegal detention, as well as the recruitment and use of child soldiers continue in many parts of the country, in some instances perpetrated by government forces. Guarantee of the safety and dignity of people returning to the country, including refugees, remains difficult (Human Rights Watch, 2007; Integrated Regional Information Networks, 2009).

Conclusions

The DRC represents a chronic emergency, with endemic poverty, conflict, violence, forced dislocation of ethnic groups, torture and rape as weapons of war, which have all had devastating effects on the population. These serious violations of international humanitarian law must be addressed to create peace, respect for human rights and dignity, equity and accountability. These factors need also to be taken into account in mental health policy, legislation and implementation for the well-being of the Congolese population.

The national mental health programme needs to be allocated a government budget so that it can be implemented. It will then be possible to begin to work towards mental health promotion, training in mental health for staff at all levels, epidemiological research, improvement of infrastructure, effective integration of mental health in primary care, and liaison with family, traditional and religious healers in the management of people with mental problems.

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Egypt

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For over a thousand years, the Hippocratic system of medicine prevailed in Europe. It went into oblivion during the Dark Ages, when there was a reversion to the demoniacal theories of mental illness. Hippocrates' works survived, however, in the library at Alexandria, where they were translated into Arabic. These and other classical works were retranslated into Latin and Greek from the 12th century on, ushering in the Renaissance.

Around 1284 CE, the Sultan of Egypt, Al Mansour Kalawoon, bequeathed one of his palaces in Cairo for the construction of a general hospital with a department of psychiatry. It soon became one of the most famous hospitals throughout the Islamic world. It was, and still is, known as Dar Al Shefa, literally the House of Healing (Okasha *et al*, 1993). Two features were remarkable for that era: the care of mental patients in a general hospital, and the involvement of the community in the welfare of the patients, which foreshadowed modern trends by six centuries (Baasher, 1975).

The mentally disturbed usually received baths, fomentation, compresses, bandaging and massage with various oils. Blood letting, cupping and cautery were also widely used. A familiar term for an antidepressant in the medieval period was *mufarrih an nafs*, 'gladdening of the spirit'. Those suffering from insomnia would be placed in a separate hall to listen to harmonious music and to hear skilled story tellers recite their tales (Buergel, 1975; Dols, 1992).

Mental health resources

Today, the population of Egypt is around 61 000 000 (National Information Centre, 1997). There is one psychiatric bed for every 6000 citizens; psychiatric hospital beds represent less than 10% of the total. These are largely concentrated in Cairo, bringing the ratio there to 1 bed per 2200 – the four public psychiatric hospitals in Cairo provide 5800 beds, and the remaining 1200 beds are distributed over the rest of Egypt (Ministry of Health, 1998). Psychiatric hospitals are currently experiencing difficulties in the provision of care, treatment and rehabilitation, as they have limited resources.

Egypt has one psychiatrist for every 130000 citizens, compared with one physician for every 500. Clinical psychologists total around 250 in the whole country, most of them also concentrated in the capital. The nurses working in the mental health field are general nurses – most have little or no training in psychiatric care. The more highly qualified nurses graduating in Egypt generally prefer to work abroad, often in the Gulf, where remuneration is much higher. There are many social workers practising in all psychiatric facilities, but they are mostly generic social workers, who have minimal graduate training in psychiatric social work. There is no training for occupational therapy in Egypt (Okasha & Karam, 1998).

Training

There are 13 medical schools in Egypt, each with a department of psychiatry (mainly providing out-patient services). Undergraduate training in psychiatry is often limited to a few days in the curriculum. There is a 4-year postgraduate psychiatric training programme in several of these schools. In 1948, Cairo University started a diploma in psychological medicine and neurology.

Health expenditure

According to United Nations Development Programme (UNDP), health expenditure, estimated as a percentage of gross domestic product (GDP), is 1% in Egypt. This is far below the minimum expenditure of 5% of GDP recommended by the World Health Organization, and may be compared with 13.7% in the USA (World Health Organization, 1996). The Ministry of Health budget constitutes 1.9% of the national budget (Ministry of Health, 1998). The allocation of resources is directed towards endemic problems such as malnutrition, parasitic infestations (e.g. bilharzia), tuberculosis and maternal and child morbidity.

In a postal survey conducted by Okasha & Karam (1998) looking at psychiatric services in several Arab countries, there was a consensus among Arab psychiatrists about the need for:

- public mental health education
- an increase in the number of psychiatrists
- upgrading of the training and education of mental health professionals
- the development of preventive and community mental healthcare services.

Research in Egypt

Egypt is the most productive country in the Middle East in terms of the number of articles published per year over the past 30 years (176 articles).

However, using another method of measuring research productivity – the number of articles per million of the population – Egypt would rank average to low (1.5 articles per million).

The region seems to lack a strategic, policy-oriented position on the research agenda. Furthermore, funding for academic research is limited and depends on the interests of the different financing organisations. On the other hand, collaboration between different centres at the Arab, regional or international level will doubtless contribute to the development of research in the Arab world (Okasha & Karam, 1998).

Policies and future directions

Egypt has a Mental Health Act dating back to 1944 and a documented health policy. Four years ago, the Ministry of Health adopted a new strategy, of centralisation of mental health services. In collaboration with several international agencies, this has facilitated the implementation of several projects to upgrade mental health services:

- a Finnish project on human resource development and the introduction of community-based services
- a UNDP project that concentrates on improving treatment services and rehabilitation for addiction
- a World Health Organization project on the inclusion of psychiatry in primary care services, as well as support for community-based services.

Mental health and culture

As in the majority of developing countries, patients tend to present with somatic psychological symptoms. This presentation of mental ill health is reflected in the pattern of consultation. Patients tend to pass through different healthcare 'filters' before they reach psychiatric clinics and hospitals. According to Goldberg & Huxley (1992), almost two-thirds of patients with psychiatric symptoms attend only their general practitioner, and only 50% of those would be recognised as having a psychiatric disorder.

In this context, traditional and religious healers play a major role in primary psychiatric care in Egypt. They deal with minor neurotic, psychosomatic and transitory psychotic states using religious and group psychotherapies, suggestion and devices such as amulets and incantations (Okasha, 1966). It was estimated that 60% of out patients at the university clinic in Cairo, which generally serves people from low socio economic classes, have been to traditional healers before attending a psychiatrist (Okasha & Hassan, 1968). In rural areas, community care is implemented without the need for healthcare workers. Egyptians, especially those living in the countryside, have a special tolerance of mental disorders and an ability to

assimilate those with a chronic mental illness. For example, these patients, and those with mild or moderate learning disabilities, may cultivate crops along with, and under the supervision of, family members.

Thus, the real challenge for mental health professionals is the first filter, that is, patients acknowledging their mental health problems. However, this challenge cannot be met without a reorganisation of both the health-providing structures and the approach to medical education and training. The latter cannot be systemically tackled without the guidance of action-oriented and policy-oriented research.

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