

## **Review article**

# **Mental health in Ethiopia EPHA Expert Group report**

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### **Introduction**

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) conceptualizes the term 'Mental Disorder' as " a clinically significant behavioral or psychological syndrome or pattern that occurs in a person that is associated with present distress (painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability'or an important loss of freedom. ..this syndrome or pattern must not be an expectable response to a particular event" (1). The 10th edition of the International Classification of Diseases (ICD- 10), similarly uses the term to imply "the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions..." (2).

Such a definition is said to have influenced the decision to include certain conditions as mental disorders (1). This decision or classification has helped and will help to study the various aspects of conditions and thereby to devise preventive, therapeutic and rehabilitative techniques.

In this way, the developed countries have shown significant progress in the identification of priority areas and management of mental health problems (mental disorders) pertaining to their situations .

In Ethiopia, various prevailing conditions (eg. culture, civil war , natural adverse conditions, policies, etc.) have been hampering such progress. Although world-wide and few local studies have indicated the presence of mental disorders to the same extent as in developed countries, the unique characteristics of the many disorders in Ethiopia, their similarities with and discrepancies from disorders in the developed countries with respect to personal, geo-social and other epidemiological and clinical variables are not known. Because of this, and possibly other reasons, the establishment of organized and situationally tailored mental health services could not materialize in the country .

Nevertheless, great effort towards improvement is being made lately by Professional Ethiopians in the field. The effort of the professionals is being appreciated by the Ministry of Health of Ethiopia, World Health Organization and other professionals in the field who are doing their best to boost their educational and material capacities in their management tasks.

The Government of Ethiopia has Commissioned the Ministry of Health to work Jut a plan of action for the development of the country , s mental health system. The action plan is reportedly submitted for approval. Also, for .the first time in the country's history , a mental health legislation was recently formulated by an inter-sectoral committee and this is also awaiting approval. This legislation will be one step ahead in facilitating mental health development and in protecting the rights (medical and social) of the mentally ill.

Given the above situations, we believe that the Ethiopian Public Health Association's (EPHA's) plan of including mental health for the short term workshop is very timely. Accordingly, this paper has the following objectives:

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- 1.. To give an update of available information on the extent of mental health problems in Ethiopia as compared to the rest of the world.
2. To review the evolution of mental health services in the country .
3. To attempt to indicate policy options, plans and interventions pertaining ,to mental health problems in the Ethiopian context.

### **The global situation**

Worldwide studies have shown the prevalence of mental health problems and their disabling effect at individual and national levels to be quite significant. This has led to the recognition, by member states of WHO, of mental health care as one of the priorities and to its inclusion in the program of primary health care. As a result, the past few decades have shown great changes in the pattern of mental health services.

In many countries, psychiatry and psychiatric services have transformed from isolation and rejection to integration and active involvement in general medical care.

The trend in the developed nations for the past three decades has been de-institutionalization shifting the treatment of the mentally ill from the confinements of lunatic asylums to general hospitals and clinics and to community care. Such moves were said to be results of three main motivating forces:

- a) Those persons, mostly professionals, who were imbued with the ideology that community care would be far better for the mentally ill.
- b) Those in the government, who thought community care would be far cheaper .
- c) An array of civil right advocates who wanted to give the mentally ill their 'right and freedom' (3).

Following de-institutionalization, various organizational patterns of mental health services have been innovated in the community .Day hospitals, half-way homes, day-care centres, addiction treatment units, domiciliary care, etc. , can be cited as examples. Each one of these. has its specialities and caters for a particular group of clientele, thus allowing coverage of the overall spectrum of clinical conditions (4).

Many developing countries, have also taken measures to provide mental health care within the framework of primary health care. Some have managed to give the service. at all levels of the

health care system from the community health service to the highest referral hospitals. Results of such moves were found to be rewarding. The Number of people attending psychiatric out-patient services at district levels rose significantly. At the same time, the number of people requiring attention at central specialized centres was reduced. Results have also shown better response of patients to treatment and public satisfaction at having the service in their own community (5).

### **Mental health problems in Ethiopia**

*Traditional Notions Regarding 1Types of Mental Health Problems:* Though not systematically categorized as in modern psychiatric nomenclature, there have, for centuries, been recognized syndromes of mental illnesses in traditional Ethiopian societies. Such syndromes are given different names in different ethnic languages.

Even though no consistent criteria are present, some of the terminologies connote the relative degree of severity of the individual's mental derangement and, accordingly, the degree to which individual patients are given/denied responsibilities. For example, in the Amharic language, "cherqun yetale" denotes a severely mentally ill person unfit for any responsibility . The Oromo word "maraattu" also denotes the same. "Wofeffe" or "nik" implies that a , person is not too reliable because he/she has inconsistent behaviour due;c: to episodic explosiveness or other unusual changes in his/her inter-personal communication. " Abbsho " is a term that describes an individual who had taken some psycho-active drug (herb ) at some earlier period in his/her life, and who later develops psychotic-like behaviour whenever taking some alcoholic drink.

*Prevalence of mental disorders in Ethiopia:* Until recently, studies on the prevalence of psychiatric conditions in the country have been scarce. The few earlier studies were done mostly by foreigners. Most of these earlier studies were done using clinical samples from attenders of out-patient clinics. Two studies, one by Giel and van Luijk (6) and the other

Table 1: **Prevalence rates of mental disorders in Ethiopia (7)**

Source	Year	Sample	Measures <sup>a</sup>	Prevalence
Adult:				
Giel and van Luijk <sup>10</sup>	1968	n=384	interview	8.6%
		Bonga Kessel	symptoms;	
Giel and Workneh <sup>11</sup>	1969	n=370	interview	9.1%
		South-west rural	kessel	
Kortmann <sup>5</sup>	1985	n=40	SRQ	12.0%

		Addis Ababa	interview	
Teferi et al. <sup>6</sup>	1988	n=2000	SRP	17.2%
		Hadiya-Kembata rural		
Samuel <sup>2</sup>	1989	n=860	SRQ	12.3%
		Jimma, mothers		
Children:				
Giel and van Luijk <sup>28</sup>	1967	n=373	Teachers=	11.3%
		Bonda attending school	report	
		4-20 years		
Giel et al. <sup>23</sup>	1968	n=381	interview	5.2%
		Rural town	SW	
		0-20 years		
Samuel <sup>2</sup>	1989	n=860	RQC	24.8%
		3-12 years	Behaviour	23.2%
		Jimma	problems	

<sup>a</sup>The Kessel classification includes explicitly psychiatric symptoms, unexplained physical symptoms, eg, psychosomatic, abnormal psychological reaction to all symptoms, and personality disorders. SRQ=24-item Self-Reporting Questionnaire of the WHO. RQC = 20-item Self-Reporting Questionnaire for Children of WHO. Behavioural problems = 54-items tapping externalizing and internalizing behaviour problems taken from Achenbach=s questionnaire.

by Kortrnann (8) reported on community surveys. The methods used by these researchers and their findings are listed in the Table 1.

The late 80's and the 90's have shown changes in psychiatric research in the country . More Ethiopians have been involved in studying mental health problems locally. Also, these latter researches are done using standard instruments sponsored by the World Health Organization (WHO) [SRQ], and the WHO and the US Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) [CIDI] to assess psychiatric conditions in different cultures (9, 10) and which are supposed to be consistent in picking out cases despite cultural variations amongst nations. The other differences between the earlier and later studies is that the later use community samples.

In spite of using different methods, the results of the various studies showed closer figures of prevalence rates. Moreover, these results were also similar to findings in other parts of Africa and developing countries elsewhere. [The works of T.V.M. Joup 1986 (10), M Dadphale 1983 (11), Harding et al. 1980 (9) can be cited as examples]. From what has been reported in studies done in the country and from worldwide statistics, we can conservatively estimate that 12% of Ethiopians suffer from mental disorders. That is, out of a population of 50 million, six million currently have some sort of psychiatric disturbance. Of these, one million or 2% of the total population are suffering from the severest form of mental illness or psychosis whereas five million or 10% are suffering from milder disorders or neurotic conditions (7).

Probably, the figures could be higher for Ethiopia if studies covered wider areas and larger samples. This assumption emanates from the recognition of the unique extent of stressful situations in which the peoples of the country have been going through for the past few decades in particular

The other aspect of prevalence studies in Ethiopia is the lack of information on. the extent of specific conditions. .Although the ICD and DSM have come up with codes for many clinical conditions under their classification system of mental disorders, only one of the researches done in the country (12) attempted to measure the prevalence of specific psychiatric illnesses. This lack is mainly due to :

a) the self-limiting coding system used in psychiatric out patient departments and in discharge summaries of in-patients. The coding system for mental illnesses allows the recording of only five classes of disorders without coding for specific psychiatric conditions. The five codes are:

1. 067 -psychosis
2. 068 -Neurosis
3. 069 -Mental retardation
4. 073 -Epilepsy
5. 078 4 -All other diseases of the nervous system

b) the lack (until recently) of standardized instruments for detecting specific psychiatric disorders in the community.

All the same, since the recent past, attempt has been going on at the different psychiatric centres to establish a pattern of recording specific diagnoses in addition to the existing five codes both at out-patient and in-patient records. Data thus collected at Amanuel Hospital show the following diagnosis pattern at out-patient and in-patient levels during a twenty-month period.

It must be clear that the population on which the hospital data are collected are not representative of the country's population for quite a few reasons. First, not many people in the country know about the existence of the medical alternative for helping the mentally ill. Second, some of those who are aware of the existence of the medical alternative refuse to accept it in principle and go elsewhere to seek help. Thirdly, the medical alternative is in acute shortage in the country Centres are available only in Addis Ababa, and other provincial cities and there are many problems which prevent a lot of patients from coming or being brought to these centres. Therefore, it is only a minority of the mentally disordered that get attention from health workers, particularly from mental health professionals. Fourthly, many mentally ill people do not come to the hospital until their illness reaches extreme severity and manifests itself in aggression, destruction or disruption of peace in some way. The fifth reason is shortage of drugs. The budget allocated for drugs in the hospital is very small and there is, in general, very frequent absence of essential psychotropic drugs in the country .People drop the idea of coming to the hospital when the-news about the absence of drugs spreads.

### **Determinants of mental health**

**Traditional Concepts:** There is probably more concordance in the notions of different ethnic and religious groups regarding the etiology of mental illnesses than regarding physical illnesses. In any ethnic or religious group, supernatural powers are given the attribute of controlling the well-being of the individual's mind. When a person goes mental awry, the cause is most of the time ascribed to the will of some supernatural force.

The will of such supernatural force(s) is said to be negatively directed towards an individual for various reasons. Some of such reasons are: a) when a person sins either by commission or omission; b) when a person contemplates of doing the forbidden; or c) where, a supernatural force acts against a person for his/her enmity towards a favoured one. People are also said to fall mentally ill if their minds are dwelt in (possessed) by spirit(s) of evil supernatural force(s). There are many assumptions as to why and when a person may be possessed by evil spirit(s). For example, when a person walks alone in the woods; when having sex in the open; when falling asleep in the meadow; when walking along the river-side around noon-time; when walking in a grave yard,... when entering a long-closed room without blessing self, etc.

In both the Christian and Moslem populations of the country , it is widely believed that there are certain individuals who have the capacity to make a person mentally ill by their magical power. Such individuals are supposed to be endowed with either good or evil spirit(s). They are feared and respected by the masses and often, offerings are given to them so that they may drive one's enemy mad or that they may protect one from going mad. The mechanisms they are said to use are often incantation, sorcery , enchantment, and certain rituals. "Debtera", "Kalicha", "Tenquai" and "Tila Wogi" are names of such powerful individuals.

*Buda (evil eye)* is another phenomenon widely believed to cause mental illness in people. When someone with the evil eye looks at a person, he/she may make that person mentally ill. The victim becomes restless, aggressive, destructive and shouts incoherently. The onset is very acute. The diagnosis is reached at later when the healer forces the victim (during exorcism) to talk about who made him ill. People could also be targeted by" evil eyes " when eating in front of others. Most victims of buda (evil eye) are children, adolescents and women, especially handsome ones.

*Danqara/Metet:* This is a unique phenomenon which is still practised by adversaries against each other. "Denqara" is an item on which the incantation of a magician ("debtara" or "tanquai") is said to have been effected. When such an item is put on the roof, door, at the gate or in the compound of a person's home or across the path of that person, the person will be expected to develop some mental illness or some other misfortune will befall that person. The items often used for such purpose are the bodies of a dead mouse, or chicken or cat. Food and grain are also sometimes used.

Poisoning through food and drink is also widely believed to be cause of mental as well as physical illnesses or death. In certain areas in the country, it is the custom for hosts to first taste the food or drinks which they offer their guest(s) to reassure the latter about the safety (poison free) of the offered food or drink. If this is not done, the guest may refuse to accept or may insist (politely) that the host should taste the food/drink. During exorcism at holy water or church healing rituals, one can hear the mentally ill talk, whilst in a trance state, about having been made ill by being poisoned via food or drink. It is well known that some physical, psychological (personal), familial, social and other environmental factors contribute either to the occurrence or perpetuation or both, of certain mental disorders. Some of such factors like malnutrition, chronic illnesses, separation, migration, natural disasters, unstable social situations, overpopulation, etc., have been very common in Ethiopia. But only one study has so far reported the association between some stressors and psychiatric symptoms (13). In that study, it was found that divorced, separated and widowed people displayed a higher frequency of psychiatric morbidity. The study also found positive correlation between chronic illnesses like hypertension, diabetes, epilepsy and chronic liver disease and higher prevalence of psychiatric disorders. Mention was made earlier of the unique stressful situation in which peoples of this country have been through for the past few decades in particular. War, dramatic environmental (natural) changes and associated famine and political torture have been shaking the stability of the mental state of citizens. Such stressors are classified amongst the highest in causing mental disorders in individuals. They produce severe stress response in everybody and require excess and prolonged coping efforts (14). Often times, such coping may fail in many individuals due to too much stress. As a result, a segment of the surviving population exposed to the above kind of adverse conditions develop psychiatric disorders. A common psychiatric disorder that is a sequel to such stressors is post traumatic stress disorder .

Post traumatic stress disorder (PTSD) is a condition which has been included in the psychiatric classification of disorders since DSM-111, 1980 (American Psychiatric Association). The major symptoms of this disorder include: a) feeling numb to the world with a lack of interest in former activities, and a sense of estrangement from others, b) reliving the trauma repeatedly in memories and in dreams, and c) anxiety , which may manifest itself in problems of sleep, concentration and alertness. The disorder may develop immediately after or as late as months after the disaster .

One need not experience the unusual stressor for oneself to develop PTSD; simply witnessing others experiencing the stress can also produce the disorder in the witness. In other words, it is not only individuals who go the war front or who are tortured and maimed, or who lose significant figures during such disasters that develop PTSD. Taking into consideration the large areas of the country where civil war at various scales had been going on for decades, the millions of people, military and civil, involved, the extent to which political torture and killings have been practised

at every corner in urban and rural settlements, etc. , we can expect a huge but unnoticed number of Ethiopians to currently suffer from PTSD .

A 1988 study revealed that 15% of the male and 9% of the female American veterans who served in Vietnam from 1964 to 1965 still suffered from PTSD 15 years after returning home (15). The author of the paper stressed on the importance of recognition of PTSD as treatment may prevent the long term psychosocial impairment (alcoholism, divorce, suicide, violence and difficulty in holding a job). It was also noted that as sufferers may complain of somatic anxiety symptoms, health workers unfamiliar with the presentations of PTSD may expose cases to unnecessary expenses for investigations and treatments. Among other significant etiological factors associated with mental illness and which have been common phenomena in the country , falinine, poverty, migration, displacement (resettlement) and parental loss, etc. , are the common ones. The impacts of these major events on the mental health of individuals in the country have not been studied.

The other ominous feature of our societies which has not been given enough attention is the spread of the use of the psychostimulant substance "chat" (*Catha edulis*), alias khat. Some botanical and epidemiological studies were done on chat over the past 3 decades. The studies mentioned that chat use was spreading and that it caused health and economic problems( 16, 17, 18). Even though sporadic case reports from abroad associated chat with psychosis (19,20,21), and records from Amanuel Hospital mention chat induced psychoses, studies so far done on chat lacked systematic and controlled analysis of its impact on the mental, physical and social well-being of individuals.

Alcohol in its various forms has been widely in use in the non-moslem parts of the country . The use of cannabis (hashish) has also recently been reported to be spreading. These two substances (alcohol and hashish) do cause different kinds of mental disorders on the users. Nevertheless, there is no estimate, in our country , of these on the mental state of individuals.

### **Mental health services in Ethiopia**

Currently, both the traditional and modern methods of treatment are used by people for their mental problems. The traditional healing methods are used more by most people. From the point of view of the majority of the population, there are reasons for the more use of traditional healings. Some of these reasons are: a) the deeply ingrained religious and inherited beliefs that all mental illnesses are of spiritual origin, and like their causations, their preventions and cure are achieved via traditional healers whose methods of treatment have a spiritual theme; b) traditional healers are more accessible; c) the fees charge by traditional healers and the cost of prescribed items are usually cheaper than that of the modern services; d) the orders of traditional healers are symbolic (of some meaning) and attractive to the masses. For example, a person said to be possessed by an evil spirit would more easily accept wearing an amulet in which are inscribed powerful exorcising figures than those bitter, unattractive tablets from hospitals; e) traditional healers identify with the population in their ways of living better than modern health workers, and the people feel more at ease and at home with the former.

Often, similar methods are used by the traditional healers to treat both physical and mental illnesses. The major traditional procedures will be mentioned here:

- a) Wearing amulets: Writings or inscriptions on goat skin or a piece of paper strip. The skin or paper strip is then folded into a tiny bundle which is then sewn in a piece of animal skin or clothing which in turn is worn by the patient. There are different formulae used by Christian and Muslim healers for use for different disorders. Some healers also give herbs, pieces of hyena skin, lip palpebrae or skin.
- b) Holy Water: This is mainly used by coptic followers but followers of other religions also use it. Bathing in or drinking holy water at intervals or for days at a go when prescribed by the priest is believed to prevent as well as cure mental illnesses. Also, sprinkling of such water on the walls and floor of one's home is said to be a sacramental against daring evil spirits.
- c) Herbal prescriptions: Concoctions of various herbs are given to patients either to chew or drink, or the herb may be prescribed to be sewn in a piece of clothing and then be worn around the neck.
- d) Performing rituals: Some rituals have traditionally been or are being performed by some sectors of the population as a sacrifice for appeasing spirits. eg. Slaying a cock of particular texture (as prescribed by the healer), moving the carcass round oneself a particular number of times, and then throwing it towards a particular (prescribed) direction. Another example is chewing the leaves or roots of a medicinal plant which is blessed by a healer and then spitting the chewed material over the patient.
- e) Exorcism by prayer: It is widely used among both the Moslem and Christian population to beseech God for His mercy upon the mentally ill.
- f) Exorcism by fumigation: This is mainly used by the healers to release the possession of evil eye or "buda". The healer burns the stem or root of some specific plant and the patient is fumed. After some time, the patient shouts and kicks and thrashes. The healer then asks who he/she (the possessing spirit) is, and later orders the evil spirit to leave. The spirit is then offered (through the patient) something to eat or drink. The offering is often a residue of the local beer, "tella", or some ash or some sort of waste material. After the patient consumes the offered material (which the spirit, not the patient is believed to have consumed), the spirit is said to have left the patient because the patient then either calms down or tells that the buda has released him/her.

### **Modern (western type) mental health services**

a) Psychiatric Centres: Until 1987 , psychiatric services were provided by Amanuel Hospital, the only mental hospital in the country , and by the clinic of the university at the Department of Psychiatry located at St. Paul's Hospital. At present, services are provided at 30 centres throughout the country .Six of these centres are in Addis Ababa; the rest are in 24 hospitals in the regions (Table 2).

Table 2: Regions with psychiatric Centres

Rgion	Number of centres	Psychiatric beds	Staff
1	1	-	Psychiatricnurse

3	5	-	Psychiatricnurse
4	11	-	Psychiatricnurse
5	2	-	Psychiatricnurse
6	4	-	Psychiatricnurse
12	1	-	Psychiatricnurse
14	6	380	Psychiatrist
			GPs
			Psychiatricnurse
			Psychologist**
			Social worker**
			Health assistant

\*\* found only in ammanuel hospital

The six centres in Addis Ababa are the Amanuel Hospital, the University Department Clinic at St. Paulos, the psychiatric units at the two army hospital, and the clinics at the A.A. University and the Prison Administration. Amanuel hospital has 350 psychiatric beds while the Army Hospital hAs 30 psychiatric beds.

*Amanuel Hospital:* Located in Addis Ababa, it is the first psychiatric centre in the country . The building of the hospital was constructed by the Italians for general purpose when the country was occupied for five years by Fascist Italy during 1935-1940. Since the defeat of the Italians, the building has been functioning as a mental hospital.

The hospital was under the Ministry of Interior and the Red Cross Society until the establishment of the Ministry of Health in 1948. Under the Ministry of Health, it was first incorporated with Menelik II Hospital, but after sometime, it started to operate as an independent mental hospital (22). For many years, it served as an asylum for confining the mentally ill. Until about nine years ago, it had more patients than the number of beds, with two to three people sharing one bed. Staff assigned by the Ministry of Health to work in the hospital were not selected by criteria for the special handling of the mentally ill.

Instead, transfer or assignment to Amanuel Hospital used to imply falling into disfavour with the Ministry .In some cases, the staff were transferred to work at the hospital when they themselves fell mentally ill (23). Even today, the facilities of the hospital are very poor. Many of the beds are occupied by long-stay (chronic) patients who have no other place to go to. There are no specialized wards. Children and adult patients stay in the same ward. Patients with different degrees of severity of illnesses are kept together .

Moreover, offender patients admitted by court order or by police request, no matter how dangerous (aggressive) they might be, stay in the same. ward with other patients. Armed soldiers (guards for offenders) from the prison administration also stay in the same ward with patients.

There are no dining rooms where the inpatients could eat or be fed properly. They eat sitting either on their beds or on the floor of their ward. The outpatient area is over- crowded with no shelter for waiting people. A multi-purpose hall is being built at present with aid from Oxfam.

**Mental Health Workers:** Before the late 60's, psychiatric services were given by foreign professionals working at Amanuel Hospital and at the University Department Clinic in St. Paulos' Hospital. Until 1987, there were only two Ethiopian psychiatrists in the country , one in the university department and one in the army. In 1990, the number of indigenous psychiatrists increased to six. That was the year when Amanuel Hospital was staffed with Ethiopian specialist psychiatrist! for the first time. Before then, the hospital used to be run by foreign specialists. At present, there are 12 psychiatrists in the country , all Ethiopians. Of these, eight work at Amanuel hospital, two senior psychiatrists work at the out-patient clinic of the university department in a general hospital in Addis Ababa, one works at the Armed Forces Hospital and one psychiatrist practices in private.

There are a total of 120 psychiatric nurses in the country giving services in the different centres mentioned above. In most centres, they work in pairs. There are three psychology and two sociology graduates working as clinical psychologists and psychiatric social workers, respectively, in Amanuel Hospital. These professionals didn't have any formal clinical training in mental health. Their work depends entirely on experience they gained while working in the hospital.

In addition, there are fourteen general doctors currently attached to Amanuel Hospital and the Psychiatry Department of the University . The psychiatric-to-population ratio for Ethiopia is at present 0.02 per 100,000.

According to an unpublished survey done two years ago, the mean psychiatrist-to-population ratio for four African Countries (Ethiopia, Tanzania; Zambia, Nigeria) was one per 1.14 million. The range was one per 900,000 for Nigeria to 1 per 6 million for Ethiopia( ). If we compare these figures with those of other countries reported many years back, we find ours to be extremely backward. To cite an example, twenty years ago, the psychiatrist-to- population ratio for Latin America was 1.52 per 100,000 and for South-East Asia, it was 1 per 100,000 (4).

**Services Available:** The main service is out-patient service, which is provided at all psychiatric centres. About 100-150 patients are seen everyday in the outpatient clinics of Amanuel Hospital, out of which 50-60 are new patients. In order to be able to see a doctor, patients or relatives have to queue in the hospital yard starting from as early as 5:30- 6:00am. But those patients who are extremely difficult to manage are seen at the emergency OPD any time of the day (24).

In-patient service is given mainly at Amanuel Hospital for civilians and at the Armed Forces Hospital for the army. Psychiatric nurses working at regional hospitals sometimes admit cases in their respective hospitals for

management, but in most instances, they refer admission requiring cases to Amanuel. This is because there are no psychiatric beds in the general hospitals in the country .At Amanuel Hospital, there is always a long list of severely ill patients waiting for days to be admitted. Many beds are occupied by chronic cases who could have been rehabilitated elsewhere, but there is no such place or home to send them to. Patients come from all parts of the country and this also lengthens the waiting period. If bed is not available, patients who need admission will go back with only one injection of an antipsychotic drug as oral medication is often not possible to administer. Patients who are brought from distant places of the country with no relatives in Addis), are likely to stay in sheltered bus stops, etc., until bed is available, as they are not accepted by hotels because of their disturbed state of mind.

There is a rudimentary occupational therapy unit in Amanuel Hospital run by unqualified attendants and serves mainly as pastime for in- patients. The psychologists help the doctors in counselling and simple psychotherapy. The two social workers' task is to assess patients' social status, locate relatives of patients, facilitate transport for discharged ones and verify documents of non-paying patients. Amanuel Hospital is also active in certifying people regarding their mental state. Sanity evaluation for certification is done by a board consisting of the psychiatrists, the psychologists and the social workers. The board is thus active in providing professional opinion to courts all over the country on the mental state of offenders who are referred to the hospital by courts for sanity evaluation. There is no forensic psychiatrist in the hospital or in the country .Another situation where board certification is often required is when employers request the hospital to assess the sanity or level of functioning of their employees. This request is made by employers for purposes of pension or change of job or location.

A drug and alcohol treatment unit was recently started within the existing unit at the University Department Clinic in St. Paul Hospital. There are no other sub-speciality services. Child and adolescent units, forensic

units, day care centres, rehabilitative services, occupational and other therapeutic services are conspicuously lacking. The main reason for absence of these services is lack of trained staff in the various specialities, although material shortage is also a significant factor . Health education in' mental health is given daily at Amanuel Hospital. Some of the other centres also give mental health education to out-patient attenders.

*Training in Mental Health:* The Department of Psychiatry in the Medical Faculty and the staff of Amanuel Hospital have been giving practice and theoretical training to under- graduate doctors. Similar training is also given to under-graduate nurses by psychiatric nurse-tutors and doctors at Amanuel Hospital. Under-graduate doctors are given the psychiatric training during their final year in the medical school. The nurses get theoretical education in their first year , and practical 11 exposure in their final (3rd) year of training. There is post -graduate training in the country for graduate doctors. All the psychiatrists in the country had their post graduate training abroad with the help of the World Health Organization and developed countries. Five of the psychiatrists were trained in the United Kingdom and the others, one each, in the USA, Netherlands, Kenya, former GDR, Cuba, Bulgaria and Yugoslavia. The starting of the Psychiatric Nurse Training in 1987 was

a break through in the development of mental health services in the country .All the 120 psychiatric nurses in the country were trained here since then. The training is given by the Psychiatry Department of the University and Amanuel Hospital, jointly. The Ministry of Health oversees the training. The World Health Organization helps materially and covers the financial expenses. The training consists of three months' intensive theoretical and practical education at Amanuel and St Paul hospitals, followed by nine months' independent practice (internship) at the respective hospitals where the trainee nurses came from. There is, however, regular supervision of the nurses every three months during this nine-month period. The nurses graduate after one year of total training. They are then assigned to the hospitals they came from to render psychiatric services. Supervision of psychiatric nurses by psychiatrists continues on a yearly basis.

### **Regional Variations**

No comparative study has yet been done regarding the extent of mental health problems in the country .All the etiologically associated factors mentioned earlier in this review affect all regions more or less equally. However , there are three factors that were or have been more prevalent in certain regions than in others. These are: war, draught/famine and the consumption and cultivation of the psycho- active substance chat/khat (*Catha edulis*).

*War and Draught:* Though the trauma due to the prolonged civil war and the few international wars has somehow affected every region and citizen, some regions obviously shouldered the brunt of suffering for decades. The Northern, Northwestern and Eastern regions are examples.

War causes mental disturbance in individuals because of several events that occur during or after it (25). Among such adverse events are: disquiet, lack of freedom and basic necessities, loss, and displacement.

*Disquiet:* War causes disturbance of the mind of people in combat zones by upsetting the routine calm which people were used to. Noise of shooting, the view of damage, witnessing killings and sight of wounded persons, sight of fatal weapons, threats and undue demands from armed soldiers, etc. all have a disquietening effect on the minds of people.

Loss of various kinds is one of the disastrous effects of war .Survivors in areas where the civil and inter-national wars had taken place had lost several things. Some lost body parts, others lost relatives or close friends, still others lost properties. Many lost a combination of these.

Those who lost their body parts have lost the capacity to function as optimally as they would like to. In addition to the disability, the lack or inadequacy of social support causes superimposed hopelessness.

Loss of loved ones by death is irreversible. When one's significant figure departs via death, the impact could be so intense that some people may find it difficult to cope with, even when the death is long expected. When such loss occurs violently and combined with other losses and adverse events, as it had been happening to lots of people in the war regions, the stress can become disastrous on the mental well-being of survivors. Loss of property is another nasty experience that people in civil war areas had been through. Life-long efforts

which were made in accumulating one's possessions became valueless in a matter of minutes or hours because of crazy destruction. Aspiration for a better life was shattered for the countless people who are left devoid of their hard earned properties. The despair of such people is compounded by the inability to revitalize their means of living after the war(s).

Losses during war are different from loss at ordinary times because among other reasons, the losses are caused suddenly and are violent. Besides, they are executed intentionally to incite suffering and humiliation in the victims . Moreover, people in war zones lack social support as damage and loss are pervasive in the region and nobody is able to help someone else.

Lack of freedom and basics: As a result of threat to their lives, people in war areas are often limited to their homes or-dug-out shelters. They become unable to move freely and secure basic necessities like food, water and other essentials. This condition leads to malnutrition and poor hygiene of family members, which in turn can lead to the development of all sorts of physical illnesses. The complex effects of deprivation and illness, especially over a prolonged period, as had been the case in some war regions of our country , could have higher contribution to psychological problems of citizens.

The populations of most draught affected regions also suffered from the direct effect of war .Conversely, the regions where war has been going on for years suffered from draught more than other regions. Some regions were affected mainly by draught. Survivors of draught/famine also suffered from loss and lack of basics, the loss being mainly through death due to starvation.

Young survivors of drought/famine and war suffer the most in such regions. Besides what has already been explained regarding effects of loss and deprivation, young (child) survivors have additional problems since they are most of the time orphaned. Orphans suffer from lack of appropriate parenting. That is, they will be deprived of a parent's loving care and guidance in preparation for their future adult life. They grow short of supervision and correction if and when they deviate from the norm in their behaviour .As adult survivors are occupied with their own problems, unfortunate orphans are left to the mercy of fate. Malnutrition affects young children of wart drought affected regions more than it does adults. This is because babies in such areas will be of low birth weight due to poor ante-natal maternal feeding; and children in countries like ours are already at a disadvantage because of the traditional discrimination which allows only the left overs to children. When the effect of draught and war are added to it, the impact becomes quite immense. The young children thus affected fail to grow both physically and emotionally. They become predisposed to mental illnesses this way.

Displacement: Where there is war and famine, displacement or migration is inevitable. The migration could be by people's own will in a way of dealing with the problem or by force from authorities. The migration can be to a safer place either within the country or abroad.

As one leaves the area where one had established one's life, one will be overwhelmed with the grief of separation. All that was familiar is left behind. Moreover one's mind becomes preoccupied with the anxiety-laden ideas or worries about what might await one in the new area. "Will one be accepted by people there? Will the culture and ways of life be agreeable to one's values? If not, how to cope with them? Will one find shelter. food and other basics? Will the weather be bearable? ...On arriving at the new place, the migrants will encounter problems in some or all of the

conditions mentioned above. Some migrants develop coping mechanisms while others fail to do so. Instead, they react with maladaptive behaviours like aggressive over-indulgence, withdrawal, etc. Such behaviours could be unacceptable to the locals of the new place and there may be negative response from these local residents. This negative response further worsens the stress on the migrants .

Only few of the major adverse situations that people in regions struck by war and draught faced have been described here. It is a proven fact that such events are significant causes of psychological morbidity in people. Some people may suffer from milder emotional problems with excess coping mechanisms while others, failing to cope, may develop incapacitating mental disorders like PTSD already mentioned.

We can therefore conclude that there can be a higher chance of developing psychiatric disorders in such regions than in other regions

**Drugs:** It was briefly mentioned earlier that the use of chat or khat is spreading. Reports of causal relationship between chat chewing and mental illness was also mentioned. There were international conferences on chat and its effects on consumers. During those conferences, chat was condemned as a cause of physical, mental and social problems(25,27). At some point, efforts were made locally through mass media to increase public awareness about the damaging effects of chat chewing.

It is despite all these facts that chat use is spreading across the country .However, those regions where the plant is cultivated are more involved than others in its consumption. These regions are the Eastern, Southern and Central regions of the country .

In some of these regions, chat is replacing other cash crops because of its higher market values and because of the less laborious cultivation( 13).

The reasons people give for chewing chat are diverse. Some, especially farmers, say that they chew to combat fatigue in their tedious daily task. Others chew chat for its appetite suppressing effect. This is not to get slimmer but to suppress the pangs of hunger as they cannot afford to buy enough food. Some chew to stay awake and alert when they read/study, drive or stay on guard posts. Others say it has medicinal value like in hypertension (whereas studies reported the effect to be the contrary) (28) .Many people chew for socializing and to get the benefit of its mood elevating effect. Some sectors chew chat as part of a religious ritual.

The export to other countries is also said to be on the rise with an increasing revenue. Chat trade is legal in the country and many people lead luxurious lives on money from its sale. As cocaine is a major source of income in some regions of Latin America, so is chat becoming for the growers and businessmen in the regions where it is cultivated. Be it due to the significance of the above advantages to people, or due to the inadequate health education regarding dangers of chat chewing, or other reasons, chat use and abuse is spreading in an alarming speed.

### **Strategies for developing mental health care systems in Ethiopia**

The famous international conference in Alma Ata defined essential health care as relevant, accessible, affordable and acceptable by the communities and involving their full participation

(29). Any serious embarkment in establishing a health care system needs to adhere to this definition if the system is to be practical and if it is going to benefit the population.

Besides, a health care system needs to address itself not only to curative aspects but also to preventive, promotive and rehabilitative measures. Only then can peoples' health qualify to the WHO definition, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

With the above points in mind, it is necessary to first list the common problems encountered in the development of mental health services. These are:

1. Negative attitude: As mentioned in the earlier part of this review, many people still ascribe mental illnesses to the individual's wrong-doings and assume that such illnesses are incurable or if curable, can only be cured through spiritual healers. By extension, this attitude is shared by some policy makers and professionals, including health workers.
2. Inaccessibility of service centres (scarcity).
3. Limited knowledge of the spectrum of mental disorders: It is only when people become too aggressive, destructive or disinhibited that they are supposed to have mental illness. Other milder forms of disorders are not considered as illnesses.
4. Centralization: Mental health services are not given in most clinics or hospitals.
5. Shortage of human resources.
6. Limited scope of management skills: The main treatment modality in the country regarding mental illnesses is confinement and drug administration. Other important preventive, curative and rehabilitative services are lacking.
7. Lack of proper planning, monitoring and evaluation: There is no department in the Ministry of Health or in the regional health bureaux that looks after the development of mental health services in the country .
8. Lack of basic statistics on the prevalence of major mental health problems.
9. Shortage of essential drugs .
10. Lack of national mental health policy. Aims of the strategies for mental health development should be:
  - a) Early recognition of mental illnesses.
  - b) Determination of priorities.
  - c) Treatment of the mentally ill as close to their homes as possible.
  - d) Decentralization and integration of mental health services with general health services.
  - e) Involve the community in the preventive, therapeutic and rehabilitative programs. To achieve these aims, we need to do the following:
    1. Decentralization of mental health services : Psychiatric services should be provided at every hospital, health centre, clinic and health post.

Advantages of decentralization are:

- a) People need not travel long distances to reach Amanuel Hospital or the few psychiatric centres elsewhere.
- b) Health workers in other fields will be more able to identify and treat or refer mentally ill people. This advantage is of paramount importance since 20-30% of attenders of any general out-patient clinic do so because of psychological problems.

c) The more familiar health workers and other people become with mental health problems and the services, the less isolated and stigmatized will the mentally ill be. d) Reduction of the excess work load at the central referral hospital.

2. Establishment of a tiered mental health service system: The degree of involvement and the range of responsibilities of health workers at the various levels of the health care system (central referral hospital, regional hospital, rural hospital, health centres, clinic, community health post) should be defined regarding mental health services. There has to be a channel for two-way referrals between higher and lower level health workers.

3. Human resources development: The curricula, for undergraduate doctors, nurses and health assistants should be revised and reconstructed in such a way to enable the future health workers to identify and treat particular mental health problems. Such basic mental health training should also be given to community health agents. In addition, efforts have to be made to give basic mental health training to trainee teachers and agricultural field workers. Teachers and agricultural field workers have direct contact with the masses and they can easily identify and refer patients to health workers. Also they can be involved in mental health education. We need to train more psychiatrists, clinical psychologists and psychiatric social workers and occupational therapists.

4. Infrastructural development: Based on priorities, centres for treatment, rehabilitation and preventive programs need to be developed in every region. This requires collaborative work amongst governmental (central and regional) and non-governmental organizations, and the local communities. Involvement of the communities is indispensable as it will only be then that infrastructures acquire relevance to the expectations and demands of the society.

5. Research: Statistical information is of very high value for proper use of resources. What priority conditions to set, how, when, where and by whom to render services requires are careful analysis of local and national situations.

The development of research activities can be facilitated if a mental health research unit with inter disciplinary involvement is established at the highest level of the mental health care 'Ystem. The functions of such a unit will be to:

- a) Identify and conduct research on pressing national and regional mental health problems.
- b) Develop and institute mechanisms to ensure the utilization of results of studies on mental health by national and regional policy makers, planners and health professionals.
- c) Provide consultative services to interested government (central and regional), international agencies and professional groups in the area of mental health.
- d) Provide in-service training on mental health research to interested professionals employed in government institutions and international agencies.
- e) Provide technical support to psychiatric residents and other graduate students who choose to conduct mental health studies as part of the requirements of their training (eg. MSc, thesis work). If and when such a research unit becomes functional, it will be a major driving force in the development of relevant research work in mental health.

6. Supply essential drugs: Drugs for the treatment of mental illnesses have always been in shortage. Many patients are under-treated due to absence or shortage of appropriate drugs. There

should be a policy for a continuous supply of at least one representative drug from the different essential groups of psychotropics.

7. Establish liaison with influential traditional healers: There is some evidence that some mild mental problems could be relieved through traditional healing procedures (30). Mental health workers should respect, work with and know more about the healing skills of such traditional healers. This way, we can

identify more problems which can be resolved by the traditional way and appropriate referral can thus be made. The traditional healers (because of their influence on the community) can also then play important roles in promoting modern mental health, and in infrastructure development.

8. Mental health promotion: Involve the community in mental health education using the mass media, or through organizations in the society; eg. youth, women's, farmers, organizations, using community leaders, religious leaders, etc. Involve the community in resource mobilization for infrastructural development.

9. National health policy: The Ethiopian government has included mental health as one area of concern in its national health policy.

However, such policy should include specific plans for mental health service development. There should be commitment to a time limited goal for the practicability of specific services. (Eg. , "in the next five years, all hospitals in the country will be staffed with psychiatric nurses.")

10. Establishment of a mental health unit within the Ministry of Health and within the regional health bureaux: The task of this unit will be planning, monitoring and evaluating mental health services nationally or regionally.

It establishes policies and lays down general guidelines. The WHO recommended the establishment of such a unit long ago. The presence of such a unit in the Ministry of Health is also one of the criteria for membership to the African Mental Health Action Group. But Ethiopia has not yet fulfilled this requirement. "Given the close dependence of mental health promotion on socio-economic conditions, there is a need for an institutional mechanism for coordinating mental health with national (or regional) development policies. ..To draw broad policy lines on mental health related issues, discussions and decision-makings take place at high government levels. However, this decision making requires an appropriate technical mechanism to furnish it with well researched, well formulated and relevant policy options, and to translate the decisions into implementable plans." (31)

Therefore, it is essential that a mental health unit be established in the MOH and in each regional health bureau. The unit within the Ministry of Health should preferably be represented by a psychiatrist.

Role of EPHA in mental health care development in Ethiopia Because of the comprehensive scope of the public health department in the health care system, we believe that EPHA can play a significant role in improving the mental health services in the country .The main areas where EPHA involvement could help most are:

- a) Training of mental health workers in the epidemiology of relevant 'subjects, in research methodology and in the management of health care systems.
- b) Research: The EPHA has members who are experts in research work. EPHA can thus play a big role in collaborating with mental health professionals and institutions in formulating and conducting research and in analysing results.
- c) Planning and evaluating: -EPHA can contribute much in devising evaluation instruments and in working out plans of action regarding mental health services.
- d) Mental health promotion: The country's health care system can benefit from EPHA's advocacy on mental health services development. EPHA has contacts with significant governmental and nongovernmental organizations within and outside the country. Within the country, EPHA can help by its contributions in priority setting, policy developments and resources allocation for a better mental health service system. One such activity is initiating contacts with other agencies relevant to the betterment of mental health services. It can also contribute by organizing seminars and workshops on mental health.

The EPHA can also help mental health institutions here by soliciting help from, "road, by identifying centres that can award scholarships in mental health, and by engaging in other similar activities which may be relevant to the development of better mental health services in the country .

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