

The social and cultural aspects of mental health in African societies

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Introduction

The World Health Organization (WHO) defines mental health as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'¹. Mental illness refers to all of the diagnosable mental disorders, which are characterised by abnormalities in thinking, feelings or behaviours.² Mental illness is closely related to vulnerability, both in its causes and in its effects.

Globally, 14 per cent of the global burden of disease is attributed to mental illness – with 75 per cent of those affected being found in low-income countries – which includes a broad spectrum of diagnoses, from common mental illnesses such as anxiety and substance abuse, to severe illnesses like psychosis. In 2002, mental disorders accounted for 5 per cent of the total burden of disease and 19 per cent of all disability in Africa. The burden of depression is particularly significant, accounting for 5 per cent of all disability. Thus, mental illness is a major cause of morbidity and a burden to the patients, their families and society.³

The African Region recognises the importance of mental health. For instance, whereas globally the focus for non-communicable diseases (NCDs) is on four main conditions – cardiovascular diseases, diabetes, cancer and chronic respiratory⁴ –the Region's priorities include haemoglobinopathies (in particular, sickle cell disease), oral and eye diseases, mental disorders, and the consequences of violence and unintentional injuries, particularly road traffic injuries.⁵ Furthermore, the high prevalence of communicable diseases, including malaria, tuberculosis and HIV/AIDS, are closely associated with mental illness.⁶

This paper looks at the social and cultural contexts of mental health in Africa and the current approaches to care. In the final section, it provides some suggestions on how best to address mental health in the Region.

The social and cultural contexts of mental health

Mental health is a socially constructed and defined concept, implying that different societies, groups, cultures, institutions and professions have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriate.⁷

Mental illness is a taboo subject that attracts stigma in much of Africa. A study conducted in Uganda revealed that the term 'depression' is not culturally acceptable amongst the population,⁸ while another study conducted in Nigeria found that people

responded with fear, avoidance and anger to those who were observed to have a mental illness. The stigma linked to mental illness can be attributed to lack of education, fear, religious reasoning and general prejudice.⁹ When surveyed on their thoughts on the causes of mental illness, over a third of Nigerian respondents (34.3 per cent) cited drug misuse as the main cause. Divine wrath and the will of God were seen as the second most prevalent reason (18.8 per cent), followed by witchcraft/spiritual possession (11.7 per cent). Very few cited genetics, family relationships or socio-economic status as possible triggers.⁹

Social stigma has meant that in much of Africa mental illness is a hidden issue equated to a silent epidemic. Many households with mentally ill persons hide them for fear of discrimination and ostracism from their communities. Girls from homes known to have mental illness are disadvantaged due to the fact that a history of mental illness severely reduces their marriage prospects. The effect of the silence on mental illness is further compounded by inadequate focus at the policy level. Lack of adequate national level financial and technical investments in addressing mental health impacts the understanding of the issue in the African context and on the available avenues for care and support.

The social environment in many African countries does not nurture good mental health, mainly due to the myriad conflicts and post-conflict situations. War and other major disasters have a large impact on the mental health and psychosocial well-being of people. Rates of mental disorder tend to double after emergencies.¹⁰ Widespread and frequent wars and internal strife disrupt social and community life and lead to hunger, disease and displacement. Internal conflicts, which are either resource-based or politically instigated, are commonplace and leave long-term mental health effects on those affected. The WHO estimates that 50 per cent of refugees have mental health problems ranging from post-traumatic stress disorder to chronic mental illness.¹¹ In addition, other natural shocks, including death, chronic diseases, floods, droughts and disease epidemics, have adverse mental health effects.

Poverty remains one of the major causative agents of mental illness. It is notable that poverty and mental health are closely related, implying that people living in poverty are more vulnerable to mental illness, while those with pre-existing mental illness are more likely to become trapped in poverty due to decreased capacity to function optimally. Poverty, exacerbated by difficult socio-economic conditions, can lead to isolation and loneliness and, in turn, to depression, especially among vulnerable persons and groups. There is thus a close relationship between the level of mental health in a community and the general level of social well-being. Furthermore, people with mental health problems are



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Only 15 per cent of countries in the region have mental health programmes for the elderly

disadvantaged in expressing their needs and having them met. In fact, mentally ill patients are more vulnerable to abuse in society and even in the facilities and institutions that are expected to care for them.

Mental health care

Most developing countries dedicate less than 2 per cent of government health budgets to mental health care.¹² According to a study by the Grand Challenges in Global Mental Health Initiative,¹³ the biggest barrier to global mental health care is the lack of an evidence-based set of primary prevention intervention methods. This indicates that mental health is one of the most under-resourced areas of public health in the African Region, even though mental health problems are on the rise. Thus, in many countries of the Region this area of public health requires more attention than it is currently receiving.

In most parts of the Region, the family remains an important resource for the support of patients with mental health problems.¹⁴ Although most families are willing to care for their sick relatives, severe mental disorders may deplete the resources of even the most willing and able families. However, as urbanisation becomes more widespread and the extended family system breaks down, the availability of critical care for the mentally ill is becoming scarce.¹⁵

The breakdown of traditional family structures and values could also be contributing to poor mental health because these result in children, youth and adults who are poorly prepared to cope with life and who may turn to alcohol and illicit drugs as coping mechanisms. Migration to urban areas has meant nuclear families are on the rise, thereby reducing the ability to pool manpower and resources to care for the mentally ill. Indeed, reducing consumption of alcohol and illicit drugs has become a major challenge for the Region (harmful use of alcohol is considered one of the four major risk factors for NCDs). Abuse of psychoactive substances is a mental health problem with strong social origins. In particular, the sources of problems due to the use of alcohol and the means of curtailing them are often found in the social fabric.¹¹

Although there has been an increase of depression and acute psychotic disorders among adolescents, adults and the elderly, the lack of early diagnosis and appropriate care turns them into chronic conditions. Unfortunately, the financial and human resources in the African Region are insufficient to address adequately the burden of mental health disorders. The Region has fewer mental health professionals than other WHO regions. For example, the median number of psychiatrists per 100,000 people is only 0.04. A similar trend is seen in the availability of psychiatric beds, whose median number per 10,000 people is 0.34. Also, only 56 per cent of African countries have community-based mental health facilities and only 37 per cent of the countries have mental health

programmes for children, while only 15 per cent have programmes for the elderly. The rise in the numbers of individuals who present with mental health problems places an even greater burden on an already under-resourced health care service in the Region.¹⁶

People trying to access mental health care are also negatively affected by the high costs. In 18 countries in the Region, the most common method of financing treatment involves out-of-pocket payments. In addition, only 20 of the countries provide disability benefits. As a result, most individuals with mental disorders do not receive any medical treatment at all, despite the fact that effective therapies exist for many of these conditions.

Traditional healers (including diviners and witchdoctors) and religious leaders (such as priests) provide a significant proportion of the care received by the mentally ill. For example, in Ethiopia about 85 per cent of emotionally disturbed people were estimated to seek help from traditional healers.¹⁷ This is because mentally ill people are usually shown empathy from the community if they visit a traditional healer than if they choose to seek help from a mental hospital.¹⁴

Although Kenya is regarded as comparatively better prepared to cater for those suffering from mental health disorders, with 47 practising psychiatrists in the private and public sectors, half of these provide services in Nairobi, while the remaining practise in other parts of the country. Mathari Hospital, located in Nairobi, is the national referral and teaching hospital for mental health patients. Its 750-bed facility is divided into two wings: a civil wing for stable patients and a maximum security unit for those suffering from severe mental problems.¹⁸ Patient safety in mental health settings and at home is not always guaranteed and greater action is required to improve this aspect of care.¹⁹

There are, however, ongoing efforts in the region to address mental health through policy and programming. For example, the Ministry of Health and Social Welfare in Liberia has partnered with organisations such as the Carter Center and Doctors of the World to establish wellness centres in each of Liberia's 15 counties.²⁰ Sierra Leone established a child-solider rehabilitation project following its ten years of civil war, providing counselling and other support to children who had lived through war.²¹ In the Democratic Republic of Congo, 'listening houses' have been set up for women who have experienced domestic violence so that they can talk through their trauma in a secure environment.²¹ The University of Cape Town in South Africa completed a project on mental health and policy whose goal was to expand mental health research in Africa, evaluate existing mental health policies in Uganda, South Africa, Zambia and Ghana, as well as develop new ones.²¹

Strategies to effectively address mental health in Africa

In order for the care of people with mental health problems to be effectively implemented, attitudes towards these conditions must be transformed. Practices such as using community health workers and peer-based support to treat less severe mental illnesses offer effective, efficient and sustainable solutions to improving on the significant lack of trained psychiatric specialists.

A cross-cultural approach that takes into account the requirements of individual communities is essential. In essence, it should

incorporate both local practices and the local languages used to express individual mental health needs. This can only be achieved if mental health is promoted as a priority. There is an urgent need for mental health champions in Africa and for the wide dissemination of consistent and coherent messages about mental health.

Stigmatisation of mental illness could be addressed through increased awareness, greater prioritisation of treatment, and enhanced support and education. Furthermore, achieving population-wide targets on NCD interventions and on the prevalent communicable diseases (including tuberculosis and HIV/AIDS) will benefit people of all ages and will contribute to improving mental health among other health outcomes.

Training primary health care workers to recognise common forms of mental ill health, especially at the first point of contact (health post or dispensary) and the provision of the necessary interventions should be a key investment for countries in the Region.^{8,14}

Policy-makers should recognise the immediate and long-term impacts of social upheavals and, even when they are not directly able to prevent them, make concerted efforts to reduce their negative effects on the psychological health of those affected.

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