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EXPERIENCE IN THE DEVELOPMENT OF MENTAL HEALTH CARE IN SUDAN

by

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I. DEMOGRAPHIC INFORMATION

Sudan is the largest country by territory in Africa (2,381,741 Square Kilometres). In March 1983 the third national census showed the population to be 21,592,582 persons with an annual increase of 2.8%.(I).

Of this population 20.2% are urban, 69.1% rural and 10.7% nomadic. The birth rate is 49 live babies per one thousand population per year. The infant mortality rate is 85 per one thousand live babies. The gross annual mortality is 24 per one thousand population (2).

2. NATIONAL MENTAL HEALTH POLICY

The roots of modern concepts of Mental Health in Sudan are contained in the works of the late Professor Tigani El Mahi (3), the founder of Modern psychiatry in Sudan (and Africa).

It was his pupil and successor T.A. Baasher, Chief Psychiatrist of Sudan 1956-69 who elaborated on those principles to formulate and implement a national mental health policy.

According to T.A. Baasher the central constituents of this policy is (a) the development of psychiatric care extra-institutionally into the community and within the socio-economic context and (b) the incorporation of psychiatric care into the total health system (4).

From a practical point a view a plan for the development of mental health care was then drawn out. This plan passed over three district phases.

2.I. Phase One (1956-65)

During this first phase T.A. Baasher attached pivotal importance on the training of mental health personnel - psychiatrists, psychologists, social workers, psychiatric medical assistants and psychiatric nurses. As a result of the gigantic efforts to recruit and train psychiatric registrars and then despatch them to complete their post-graduate qualification abroad (in the U.K.) the number of psychiatrists in the department increased from only one in 1956 and two in 1960 to nine by the end of 1965.

Meanwhile, trained psychiatric medical assistants were sent abroad to intensify their knowledge and experience in a reputable centre (Asfouria in Lebanon). Five social workers were recruited and given proper in-service training in psychiatric social work. One clinical psychologist joined the department and was later helped to proceed for post-graduate study abroad. Qualified general nurses were given in-service training to become psychiatric nurses.

By the end of 1965 the Psychiatric Department of the Ministry of Health was adequately manned to manage the bulk of psychiatric morbidity on an ambulatory and domiciliary basis from the Clinic for Nervous Disorders, Khartoum North and to offer in-patient care for special categories of cases at the psychiatric ward of Khartoum Teaching Hospital (5). Moreover, the clinic shouldered the duty of teaching psychiatry to the students of the Faculty of Medicine, High Nursing College, Medical Assistants' School, and nurses' schools. The clinic dealt also with all medico-legal cases gradually transforming the custodial control of these victims into a more humane re-arrangement.

2.2. Phase two (I966 - 74).

Having prepared the trained medical and other staff, the scene was prepared for the second phase: outward expansion. This demanded a balanced move along two dimensions: vertically to consolidate existing services and horisontally to spread out into various regions of the country for better accessibility and delivery of services.

During this phase the number of psychiatric units increased from one unit in the capital of the country to eight units covering seven other provinces of the north, east, middle and western regions of Sudan. These units are located at Omdurman (I965), Port Sudan (I966), Wad Medani (I967), El Obeid (I968), Atbara (I972) and Kosti (I974), Kassala (1973).

Established on the model of the parent unit, each of these units has a basic out-patient clinic and a subsidiary in-patient facility for short-term admission in a special ward of the provincial hospital.

2.3. Phase Three (I975-83).

It has been planned that by I983 there would be complete coverage of the rest of the country. Eight new units were to be established, one in each of the remaining provincial capitals. Unfortunately this plan could not be carried out because of lack in material and human resources. The biggest set-back was the unexpectedly poor yield of qualified psychiatrists. Although the training programme of psychiatric registrars was going on according to the plan, most of those expected to return to the country after qualification either did not come back or migrated later to work in some other countries. Thus although the total number of Sudanese psychiatrists is now above fifty, only fifteen of them work inside the country. The number of psychiatrists working for the Ministry of Health at present falls short of that of I966.

3. MENTAL HEALTH SERVICES

Mental health services in Sudan were inaugurated in I950. Prior to that, there had been no mental health institutions of any kind. In that year a community clinic was opened in Khartoum North (6). More than a decade later this pioneer facility was complemented by the establishment of its in-patient counter-part

The Psychiatric Ward in Khartoum Teaching Hospital. This was followed by the opening of eight provincial units with similar emphasis on out-patient and domiciliary treatment, but some allowance for admission on necessity to psychiatric beds in provincial general hospitals.
The first and only Mental Hospital in Sudan (Tigani El Mahi Psychiatric Hospital in Omdurman) was opened in I972. This development was not a retreat from the policy of extra-institutional orientation. It has been dictated by the pressing need for a specialised teaching, training and research centre.

At present we have eight out-patient units dealing with about 95% of psychiatric cases reporting for treatment. Their total daily attendance is about 800 cases, I5-20% of which are new attendants.

In all we have 250 beds for psychiatric pateints: 90 beds in Tigani El Mahi Hospital, and I60 in eight psychiatric wards in eight provincial general hospitals.

We have I5 qualified psychiatrists working in Sudan. Of these 8 are employed by the Ministry of Health, 2 by the University of Khartoum, I by the University of Gezira, I by the Medical Corps (Military Hospital) and 3 work as full-time private practitioners.

There are 2I medical officers working in our psychiatric units and at present we have only one psychiatry registrar.

We have I8 qualified psychiatric medical assistants, 3 specialised staff nurses and 34 qualified ordinary nurses. There are I4 clinical psychologists and I6 psychiatric social workers.

4. ORGANIZATION OF MENTAL HEALTH SERVICES

4.I. Administration

The Director-General of Mental Health who is also the chief psychiatrist represents his department at the highest administrative level in the Ministry of Health. He has an equal job status to the Under-Secretary of the Ministry (group one). He is a permanent member of the administration board of the Ministry and of the supreme advisory board of the Minister of Health. He is responsible for planning, organization and administration of mental health services in the country.

With the implementation of the policy of decentralization and creation of autonomous regional governments, the senior consultant psychiatrist in each region became the head of mental health services in his region, being responsible to the regional Minister of Health.

4.2. Multidisciplinary activity

There are several mechanisms for national coordination of mental health care for dealing with some specific problems. The National Council for Prevention of Addiction includes leading psychiatrists as well as sociologists, psychiologists, lawyers, police men, educationists and publicists. The institute of Traditional Medicine incorporates the activity of psychiatrists with that of a wide range of medical and other professionals in appraisal and critical evaluation of existing traditional healing practices.

4.3. Mental Health Legislation

The Public Health Act, I975 repealed the previous Public Health Ordinance I939. Chapter XIII of this act is devoted to Mental Health. Article 73 deals with the constitution of the Province Mental Health Board (PMHB) subordinate to the Commissioner who is its chairman and his assistant who is its rapporteur. Its members include the psychiatrist in charge and representatives of each of the security organ, social care department, prisons department, Attorney General's Chambers, and three of the members of the Province Health Committee.

The PMHB has the following functions:-

(a) to undertake studies and research in psychological, mental and nervous diseases and disturbances and provide protection, treatment and the necessary care for those suffering from the same and to endeavour to establish the necessary health centres for treatment of mental diseases in the province according to the conditions prescribed by any regulations or orders made under this act.

(b) to set up mental health committees.

(c) to order detention of any patient whose detention is recommended by the psychiatrist if he constitutes a danger to himself or others and take such legal measures before any competent court for attachment of the property of such patient and restricting disposal there-of until his recovery.

(d) to receive monthly reports from the psychiatrist on the detained patients and take such measures as it deems appropriate in respect of such reports.

(e) to make the necessary by - laws ..... (7).

4.4. Cost of psychiatric treatment

In state-owned psychiatric out-patient units belonging to the Ministry of Health, the Universities or Medical Corps (military hospital) treatment is provided free of charge including any drugs available at the Unit's pharmacy. In state-owned hospitals in-patient treatment is also free of charge in third class wards. Those who choose to be admitted in first or second class would have to pay by themselves or by their employer a fixed rate per bed per day, but would not pay for the medical care or the drug available at the hospital pharmacy.

In the private sector, many psychiatrists are running private out-patient clinics on part-time or full-time basis. In these clinics treatment charges have to be met by the patients, their relatives or their employers. Private hospitals can also admit such patients and in such cases the individual or his employer would pay the hospital charge, the cost of drugs and the doctor's fees.

4.5. Rehabilitation Programmes

No special mental health rehabilitation programme exists in Sudan yet. However, the therapeutic team headed by the psychiatrists endeavours tries to push the patient back to his job as soon as possible. This is facilitated by the prevailing atmosphere of family support and peer empathy. During the phase of active treatment the patient is given medical rest from work with full salary for up to six months followed by another period of up to six months on half-salary. Thanks to the achievements of contemporary psychopharmaceuticals, psychotherapy and social therapy with involvement of the family and surrounding community in helping the patient, few cases would need to stay away from work for so many months. In chronic cases where return to previous work can not be achieved, a medical board is held to declare the patient medically unfit for further pursuance of the particular job, thereby securing for him his after-service rights. Simultaneously the therapeutic team would help the patient to obtain and adjust to some other job or occupation.

4.6. Links with Primary Health Service

As the care of mental health services in Sudan is extra - institutional with out-patient Units serving ambulatory patients in each catchment area, referral of psychiatric cases from primary health care units goes on fairly easily. However, the present distribution of psychiatric units does not permit an adequate degree of accessibility to these facilities. In a territorially vast country like Sudan with inadequate transport in many parts of it, there is a particular need for developing closer links between mental health services and primary health care units. Yet, our plans for integration of these services are based on a more basic conceptualisation of the inter-relationship and inseparability of body and mind. Trained psychiatric personnel at some level or another should be included in the team of primary health care. The activity of this personnel includes dealings with local family, educational and social agencies.

5. TRAINING IN MENTAL HEALTH CARE

The University of Khartoum is about to run a post-graduate training programme in psychiatry. It is intended to be a three year course awarding the degree of Master of Psychological Medicine. The details of this programme have not yet been worked out and some time may be needed before its pre-requisites are obtained.

In Sudan we have a special school for training psychiatric Medical Assistants. The recruits are usually qualified nurses with adequate experience and high merits who pass an admission competative examination. The duration of the course is three years. In practicse, psychiatric medical assistants have proved to be capable of initial handling and post-therapeutic follow-up of psychiatric cases at the primary health care level. At present they man the reception of new arrivals at our psychiatric units. They deal with most of the simple problems and refer the others to a higher level of qualification.

6. BASIC ORIENTATIONS OF SUDANESE PSYCHIATRY

Over the years, from the explorative efforts of the forties to our present multifunctionary activity, sudanese psychiatry has acquired some distinct orientations in its attitudes to mental health problems and their tackling within their specific socio-cultural setting.

The fundamental constituents of the emerging school of sudanese psychiatry are summarized in the following :

6.1. Ecclectic disposition :

Drawing freely from the achievements of contemporary psychiatry, nothing is accepted or rejected at face value. Critical appraisal and practical testing are necessary. We belong everywhere, but nowhere.

6.2 Extra-institutional orientation :

The core of our activities is ambulatory and, whenever possible, domiciliary based.Patients' consultations are carried out mostly in extra-hospital facilities (out-patient units). 96 % of all patients are found to be manageable without resort to hospitalization.

6.3 Involvement of family in therapy :

With the patient's consent, accompanying family members are actively encouraged to participate not only in interviews and discusssions, but also in administration of therapy. Given necessary instructions and explanations these family members proved to be our most reliable "nurses". Thanks to this, no more than 4 % of all our patients are in need for hospitalization and even then, not for any longer than 2-3 weeks.

6.4. Peripheral delivery of services :

Instead of patients travelling to receive treatment at centrally located facilities, with minimal starting pre-requisites, psychiatric units are stretched out to districts. Well-trained psychiatric medical assistants can cover primary mental health care requirements, even in areas where no trained medical doctors are around.

6.5. In-service treatment :

Thanks to the prevailing extra-institutional orientation, active family involvement and peripheral delivery of services, the patient's return to his own occupation is secured in the shortest possible time. Starting with light duties (qualitative and/or quantitative reduction of work load), the patient is allowed to gradually return to normal occupational duties in an atmosphere of emphathy and emotional support from both the employer and surrounding work-mates.

6.6. Integration of psychiatry with general medicine :

Mental health facilities are incorporated with general medical facilities at both the ambulatory and in-patient level. For this purpose, psychiatric wards in general hospitals are encoraged and held in preference to separate mental hospitals.

6.7. Multi-disciplinary mental health team-work :

The therapeutic mental health team is constituted of a psychiatrist, psychologist, psychiatric social worker and psychiatric staff nurse. With proper training of its constituent

members and clear definition of the roles of these members, they can collectively cater for all the bio-psycho-social aspects of mental health problems.

6.8. Interaction with traditional healers

Mental health problems can only be tackled in relevance to the socio-cultural setting in which they arise. Time-honoured methods and techniques of traditional, particularly faith healing deserve scientific attention. Their critical evaluation should go hand in hand with positive interaction and creative collaboration with their most prospective and fruitful modalities.

6.9. Research activity:

Priority is given to studies determining the magnitude and trends of mental health problems in our community. Observation of psycho-social phenomena and study of their dynamics (e.g. urbanization and rapid social change, emigration, transettlement, etc.) provide data of paramount significance for the appropriate planning of services and the priorities of their delivery.

These are the major orientations and current pre-occupations of Sudanese Psychiatry.

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