WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

Intercountry Group Meeting on the [illegible] of Mental Health Programme:
Amman, 24 - 28 September 1983.

EM/INT.GRP.MTG.DEV.MHP./9

Basic Mental Health Care in Primary Care: The Shagara - Jebel Awlia Experience

BY:
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Abstract

An attempt has been made in this paper to outline some of the prominent features of the WHO Collaborative Study on Stratrgies for Extending Mental Health Care as it pertains to the project area in the Sudan.

The substantive findings of the study indicate that integration of mental health component into preventive, curative and rehabilitative care at rural community level is feasible. The existing health staff can, after a limited training, recognize the majority of psychiatric disorders attending general health facilities and intervene effectively by providing treatment and following up patients.

Introduction:**

The recognition that mental disorders constitute a major public health problem in all parts of the World has led to a search for ways to apply effective methods of treatment and control. In the developing countries lack of trained personnel has long been seen as the greatest single obstacle to providing care on a wider scale

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(**) In part, this a quotation from the introduction to the Protocol of the Study.

and there has been strenuous efforts to increase the number of psychiatrists and psychiatric nurses. However, even in those Third World Countries where a nucleus of trained mental health professionals now exist it has not been possible to provide coverage of mental health services for more than a small part of the population. Furthermore, in many countries a substantial proportion of resources devoted to mental health care is absorbed in the maintenance of central, custodial mental hospitals.

As a result, a number of leading psychiatrists and others have advocated the introduction of mental health care into general health services and the provision of training for existing health cadres. This policy "decentralization and integration of mental health care"- was met with cautious approval from many public health administrators and health planners and has been successfully pursued in the establishment of psychiatric units with out-patient clinics in general hospitals. This approach represented an important step in the development of more effective mental health services. Its main limitation arises from the fact that in many countries a large proportion of the population do not have direct access to general hospitals so that the vital services of diagnosis and maintenance therapy are not readily available. It is in this context that the Collaborative* Study on Strategies for Extending Mental Health Care has been conceived and planned using as its guiding principle the recommendations of the WHO Expert Committee'

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*) The WHO Collaborative Study on Strategies for Extending Mental Health Care is being carried out in Seven geographically defined areas in Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan and is designed to develop and evaluate alternative and low cost methods of mental health care(including training methods) in developing countries.

on the organization of mental health services in developing countries which met in October 1974 (WHO 1975).

The study started in the Sudan in 1976 according to a plan of action agreed upon by the collaborating investigators. The assumptions underlying the primary health care approach and extension of mental health care were taken into consideration.

The Study Area in the Sudan :-

Shagara - Kalakla - Jebel Awlia is tha area chosen for evaluative study. It is a semi-rural periurban agricultural zone between the White and the Blue Niles 20 - 50 kilometres south of Khartoum Province . Most of the area is connected with a constructed road to the city of Khartoum, while the rest is scattered within a few miles east and west the road.

The population was estimated at about 59,000 inhabitants. Previous visits to the Area and information from general practioners, medical assistants and other health personnel, local government administrators and some of the residents had shown that mental disorders do exist in the area. Moreover, a psychiatric field survey, carried out among children in part of the area, has confirmed this (Baasher and Ibrahim 1972). In addition, few patients occasionally reported to the department of psychiatry in Khartoum Teaching Hospital and the Khartoum North Clinic for Nervous Disorders.

There were ten primary health care facilities in the form of dressing stations, dispensaries, health centres as well as one rural hospital in Jebel Awlia. The area is devoid of any kind of mental health services. Staff categories are the medical officers, dentists, medical assistants, registered nurses, nursing auxiliaries, midwives and sanitary overseers. Religious and other traditional healers exist and practice their native

curative methods in the area. Public services like schools, police were available ; but electricity and clean tap water are only found at limited part of the area.

Method of the Study :-

This was based on the overall plan of action,* with the help and cooperation of the local health authorities and community leaders, a series of baseline data were collected by our research team members. Various research instruments** were used. The information was compited in schedules and sent to Geneva for data processing and analysis. According to the phase of the study, the appropriate interventions were applied. This included brief training*** course to health workers of the area.

Results:-

The frequency of psychiatric disorders among primary health facility attenders was found to be 10.5 - 17.7% for adults, 11 - 29% for children . Most patients showed neurotic disorders . The primary health workers missed or passed undiagnosed $\frac{2}{3}$ of adults and 5/6 of children with mental disorders. Those staff who had received some mental health training reacted positively; their attitudes to mentally ill were understanding and enlighted. Cases of epilepsy and psychosis were found at the rate of 5 - 10 per 1000 population in the community, results similar to field surveys carried out in entire population of a geographically defined areas in Taiwan (Lin 1953), Nigeria (Leighton et al 1963) and India (Dube 1970).

(*) appendix (i)

(**) see appendix (ii)

(***) Some details with regard to methodology and study have been reported in Planning Interventions Appendix(iii)

It was striking that patients were brought forward by local people once they realize that treatment will be locally available. Patients and their families had been eager to start and continue with treatment. Another outstanding feature was that key informants* approached had been able to name three or four persons suffering from mental disorders; over twice as many as the blind and physically handicapped people known to them. They regarded major mental illness as serious socially disabling and require help of traditional healers. Following the intervention phase of brief training to health workers in the area, significant changes in their attitudes, towards the mentally ill, their knowledge, diagnostic accuracy and management skill had occurred. Similarly, community reactions prejudice and attitudes against the psychiatricly ill became favourable.

Discussion: -

Sudan is one of the WHO member states strongly committed to the Alma-Ata Declaration and had adopted the recommendations of the International Conference on Primary Health Care in Sept. 1978. Primary Health Care figures third in the priority scale in our National Health Programme 1977/78 - 1983/84. There is evidence from annual reports and experience that its implementation has been smooth and satisfactory. Because Sudan had a health care delivery system developed several decades ago similar to new one proposed by the WHO. Yet, there is no clear indication of incoporating mental health within the Programme. This is not surprising, because mental health policy has not been reviewed and psychiatry still accorded very low priority. The resources of mental health care are very meagre at the moment.

(*) defined as the influential figures and personalities well informed about and acquainted with the people of the study area.

The results of this study demonstrate that the existing primary health facilities attract a large number of patients suffering from neurotic disorders. Epileptic and psychotic patients remain disabled in the community undetected by health workers. Health staff need regular contact with community leaders, teachers, religious healers and policemen, if such cases are to be detected, diagnosed and treated. Contact with school children and old people is as well important for the same above reasons. This could only be achieved through prerequists of training and reorientation of primary health personnel in mental health.

For practical purposes, only few priority mental disorders should be seen at primary care facilities. These are: (i) acute schizophrenia, mania, (ii) grand mal epilepsy, (iii) chronic psychosis, schizophrenia, (iv) depressions. Psychotropic drugs which could be safely handled by the most simply trained staff are chlorpromazine, phenobarbitone, amitriptyline and diazepam.

The essential tasks required from the primary health worker are:(i) recognition of psychiatric emergency, (ii) contanment of the patient by bringing him to place of safety humanely without provocation (iii) control of acute excitement by using a phenothiazine drug, (iv) observation of possible organic cause (v) involvement of the family and encouraging regular contact of family with the patient.

Conclusions:-

The Shagara Jebel Awlia experience demonstrated that effective set of interventions for defined priority mental disorders can be devised within rigorous resource limits. The amount of additional resources required to integrate basic mental care into the primary health care are fully justified. The results of the study provide a substantial basis for future community mental health programme to the Sudan. The existing health

staff are capable of acquiring mental health knowledge and skills and applying them to provide care for the mentally ill. Noteable positive shifts in community attitudes and reactions towards individuals suffering from disabling mental disorders have occurred.

It can be concluded that nation-wide application of what has been achieved in this study is timely. But the outstanding obstacles are of political, administrative and managerial kind.

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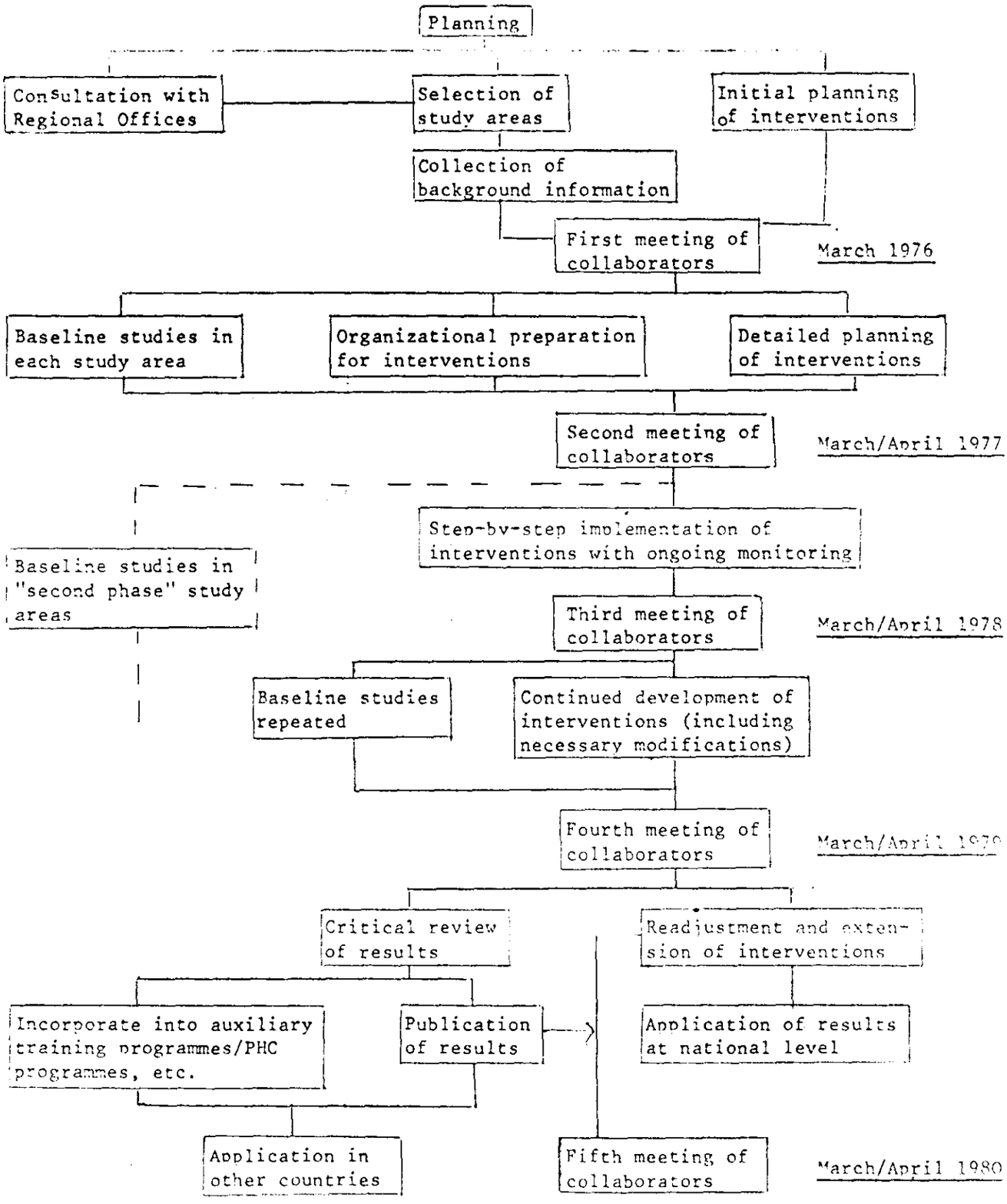
COLLABORATIVE STUDY ON STRATEGIES FOR EXTENDING MENTAL HEALTH CARE

Overall plan of action 1975-1980 **Appendix (i)**



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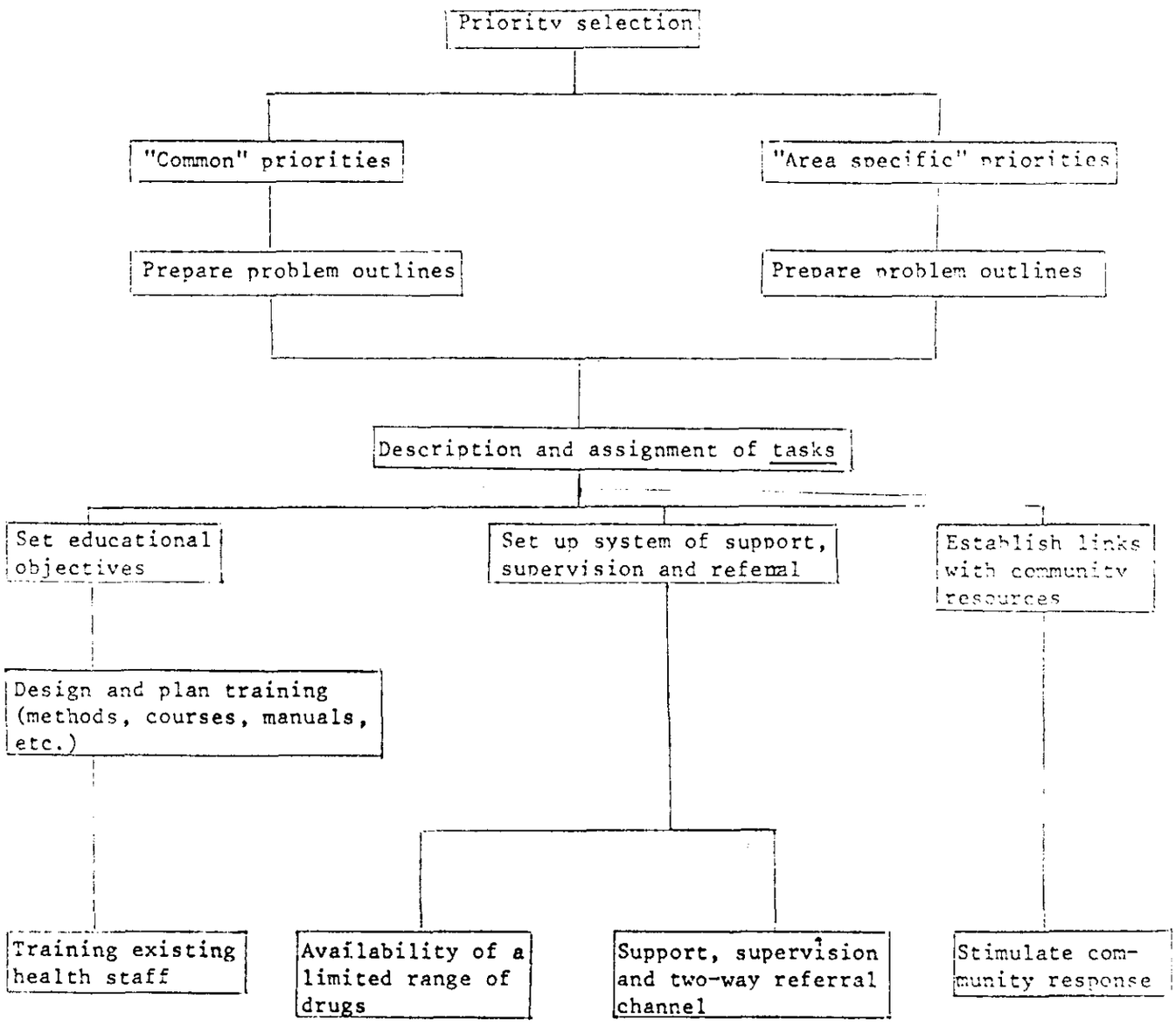
COLLABORATIVE STUDY ON STRATEGIES FOR EXTENDING MENTAL HEALTH CARE

Planning interventions

Appendix (iii)



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Appendix (ii):-

WHO Collaborative Study on Strategies for Extending Mental Health Care.

Instruments used:

(1)	Health Staff Interview	(HSI)
(2)	Self Reporting Questionnaire	(SRQ)
(3)	Reporting Questionnaire for Children	(RQC)
(4)	Health Staff Rating	(HSR)
(5)	Present State Examination	(PSE)
(6)	Disability Assessment Schedule	(PAS)
(7)	Key Informant Interview	(KII)
(8)	Social Unit Rating	(SUR)
(9)	Follow Up Interview for Children	(FIC)
(10)	Diagnostic Assessment Form	(DAF)