EPIDEMIOLOGICAL PSYCHIATRY IN AFRICA

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The study of the distributions of psychiatric disorders in space and time within African populations, and of the factors that influence these distributions (Lilienfeld, 1957) has had very limited scope in black Africa. Although the drawbacks that have characterised the various previous attempts at epidemiological data collection in black Africa will be highlighted when some of these studies are cited, some pertinent general background information is thought necessary by way of introduction.

One of the most important drawbacks to collecting reliable information about African communities is the absence of accurate vital statistics about African populations. For example, data that have been correlated with age in the continent in the past are at best very approximate. Attempts have in recent times been made by many African governments to get accurate census. Political considerations amongst other factors in some countries have rendered many such figures unreliable. Another important drawback is the very low level of literacy of the majority of African populations. This factor has consistently highlighted the need to train more indigenous African workers in the field of epidemiology. One important factor that has adversely affected the value of the findings of workers from

different cultures is the Africans' notion of what is deviant as this has always influenced what is transmitted through interpreters to previous such investigators.

In some respects, the statistics of mental disorders in black Africa is still largely at the stage of relying on hospital returns. The reasons for this state of affairs are to be found in both the investigator and the investigated. Even though psychiatric workers in Africa accept that proper assessment of the prevalence of different types of psychiatric disorders in a community can serve as a basis for the prevention, treatment and control of these disorders, their numerical strength forces them to adapt what is known in other cultures to their local conditions.

Boroffka (1973), writing about Mental Illness in Lagos, stressed the effects of the shortage of trained personnel in Africa. Although his account of in-patient populations of Yaba Mental Hospital showed that between 1917 and 1965, the annual admission rate to the hospital varied between 0.6 and 1% of the population, he was quick to point out that the hospital statistics did not give the true prevalence or incidence of mental disorders in Lagos. Some of the reasons for the non-reliability of hospital statistics in Africa in particular include the following:

(1) Hospital statistics do not take account of many cases which are being treated by native and faith healers. Some Nigerian patients patronise traditional healing facilities because

they believe that Western forms of treatment are either totally ineffective or offer only temporary relief.

(2) Hospital statistics, particularly those obtained from mental hospitals, do not take account of the large numbers of African patients who report in General hospitals with psychosomatic complaints or whose physical complaints are "substitutes" for emotional problems.

(3) Hospital Statistics do not take account of cases of psychoses who become vagrants and either perish in the bush, on the highways or end up in prisons.

(4) General hospitals, dispensaries, health centres etc. are few and psychiatric institutions are rarer still in many parts of black Africa. Many of its populations are deterred by sheer distance from reaching available hospital facilities. Such available hospital records are therefore inadequate sources of prevalence or incidence rates of psychiatric disorders in Africa.

In developed parts of the world, the organisation of health services is such that records from private treatment facilities supplement well-kept hospital records. Such records give valuable indices of psychiatric disorders in such countries. In many parts of Africa, records of the local population's contacts with private clinics or hospitals are very haphazard or non-existent. This is partly due to the load of work imposed by the teaming populations on the few clinics.

Some records in such centres are not more than the name of the patient and the number of injections that have been prescribed.

More recent workers in Africa have moved slightly forward by surveying literate populations. Examples of this attempt are surveys of psychiatric morbidity among students (Younis 1974, German and Arya, 1969). Younis (1974) surveyed a total population of 5,856 Khartoum University Students at risk and found that 3.76 per cent. had medically detected psychiatric disorders. Of these, 2.2 per cent of the total population surveyed (59 per cent. of students attending for psychiatric reasons) were found to suffer from anxiety neurosis; 0.9 per cent. were suffering from depression and 0.4 per cent. of the student population were found to be suffering from Schizophrenia. German and Arya (1969) found that out of a total population of 1351 students of Makerere University College at risk, 1122 (83 per cent.) attended the University Health Service. Out of these, 10.8 per cent. were found to suffer from a psychiatric disorders. Of these, 9.3 per cent. of clinic attenders but 85.9 per cent. of all psychiatric cases were judged to be suffering from the neuroses. These important studies give useful information about the health needs of the populations studied. The results may help to uncover some aspects of the associations between studying and psychiatric disorders in African settings, subject to great socio-cultural upheavals. These surveys could not clarify why some of the African students "escaped" the "psychiatric" consultations. Surveys that take account of the varying social and cultural backgrounds of the populations would, perhaps, have allowed a deeper appraisal of

the interplay of factors responsible for the psychiatric morbidity detected among these segments of the African populations.

Mindful of the various factors that militate against reliable epidemiological surveys in Africa, Giel and van Luijk (1969, 1969/70), Dormaar, Giel and van Luijk (1974) have adopted a different approach to meet some of the problems. By surveying various sections of the community, they have been able to give some idea of the prevalence of psychiatric disorders in Ethiopia. They carried out their surveys in a rural village, in a small road-side town and two contrasting out-patient populations. Their surveys of the rural village and the small town showed that 8.6 to 9.1 per cent. of the population appeared to have psychiatric symptoms which were sufficiently serious to cause disability. These two surveys convinced the workers that mental illness mainly psychoneurotic or psychosomatic in nature was equally common whatever the degree of urbanisation. Their surveys of the two contrasting out-patient populations, namely, a country out-patient clinic serving predominantly agricultural workers and a city out-patient clinic serving a population of economically well-off police personnel and their relatives, showed that psychiatric illness in the rural out-patient population was 6.8 per cent. compared with 16.2 per cent. in the city out-patient population. The interesting findings in the various surveys by these workers included the higher prevalence rates of psychiatric morbidity compared with those of infectious diseases (Giel and van Luijk, 1969).

Although the Ethiopian surveys went some way in obviating the difficulties posed by the low level of sophistication of the local populations, their attitudes to various types of illness, the prevailing poor health services etc., the gap created by difficulties of communication, cultural differences, between the investigators and the local populations certainly detracted from the validity of their findings.

The epidemiological method that appears to hold the greatest promise of reliability particularly in Africa is field surveys. On the African scene, the survey by Leighton, Lambo and others (Cornell-Aro Mental Health Project 1963) of psychiatric disorders among the Yoruba satisfied many of the requirements that guarantee the collection of reliable data. By means of a questionnaire designed to be locally sensitive in "tapping" symptoms of psychiatric significance, a total of 262 respondents from 15 villages, 64 respondents from the city of Abeokuta and 59 respondents from Aro Mental Hospital were surveyed. The results were compared with similarly designed surveys in North America. Fifteen per cent. of respondents from the villages compared with 19 per cent. from the city of Abeokuta and 33 per cent. from Stirling County were found to have significant psychiatric impairment. The majority of the respondents were found to have psychophysiologic and psychoneurotic disorders compared with the major psychiatric disorders.

The workers were quick to point out the drawbacks against which their findings were to be interpreted. They particularly pointed out the possibility of cultural distortion. The barrier posed by

problems of communication, never minimised by interpreters, is considerable in such designs.

This review has only dealt with a few surveys in the English speaking countries of black Africa. Even then, the effort has been curtailed by limited library facilities. Efforts in the French-speaking countries of Africa are not included in this review. In conclusion, it could be stated that with the present pace of development in many African countries including their health services, many of the difficulties that are in the way of reliable epidemiological surveys will be minimised. In particular, indigenous personnel sharing the same world-view of problems as the survey population are more likely to reduce the amount of cultural distortion that characterise previous surveys in Africa.

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