Editorial

Mental health services in the Arab world

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Introduction

This paper aims to provide an overview of the status of mental health services and research in the Arab world. Psychiatric associations and societies in the region were surveyed by post about the status of their mental health services and whether there existed specific policies and legislation covering mental health (a "Mental Health Act").

Background

Mental health services provided by each of the 22 countries which make up the League of Arab Nations show several variations. A high per capita income does not necessarily translate into a high standard of service provision. The ratio of mental health services to population, the availability of a mental health act and the space allocated to the study of mental health in medical curricula, are only a few of the concerns expressed by colleagues in different Arab countries.

The region's population is approximately 275 million, with Egypt having the highest population density (Table 1). The number of doctors per capita is highest in Lebanon and lowest in Tunisia, although

Table 1 **Medical personnel in relation to population in selected Arab countries**

Country	No. of doctors per capita	No. of nurses per capita	Ratio of doctors to nurses
Algeria	1064	–	–
Bahrain	775	–	–
Egypt	770	–	–
Iraq	1667	1370	1:1.2
Jordan	649	641	1:1.0
Kuwait	690	–	–
Lebanon	413	2174	1:0.2
Libyan Arab Jamahiriya	962	328	1:2.9
Morocco	–	–	–
Oman	1100	–	–
Qatar	530	–	–
Saudi Arabia	704	310	1:2.2
Sudan	–	–	–
Syrian Arab Republic	1220	1031	1:1.1
Tunisia	1852	407	1:4.5
United Arab Emirates	1042	568	1:1.8
Yemen, Republic of	4348	1818	1:2.3

Source: mail survey of psychiatrists and psychiatric associations

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Table 2 **Health expenditure in comparison to military expenditure in selected Arab countries**

Country	Health expenditure as % of GDP	Military expenditure as % of GDP	Military expenditure as % of health and education expenditure
Algeria	5.4	2.7	11
Bahrain	–	5.6	41
Egypt	1.0	6.0	52
Iraq	–	21.1	271
Jordan	–	–	138
Kuwait	–	62.4	88
Lebanon	–	5.0	–
Libyan Arab Jamahiriya	3.3	6.3	71
Morocco	0.9	4.0	72
Oman	–	17.5	293
Qatar	–	–	192
Saudi Arabia	0.4	11.8	151
Sudan	0.5	15.8	44
Syrian Arab Republic	1.8	16.6	373
Tunisia	3.1	3.3	31
United Arab Emirates	–	14.6	44
Yemen, Republic of	1.5	9.3	197

Source: Human development report, 1993. *Geneva, United Nations Development Programme, 1993* and World development report 1993. *Washington DC, World Bank, 1993.*
GDP = gross domestic product

Tunisia has the highest number of nurses per capita (Table 1). Health expenditure as a percentage of gross domestic product (GDP) is highest in Algeria and lowest in the Syrian Arab Republic. It is interesting to compare total combined expenditure on health and education in the region to total miltary expenditure, to understand the impact of political tension on the status of basic services (Table 2).

In all Arab countries health services are provided by both the public (government) and private sectors. In some countries insurance systems contribute to the provision of services. The proportional use of the different health providers varies from country to country, depending on prevailing economic policies. Nongovernmental organizations (NGOs) have come to be recognized as important players in the provision of health services, especially in countries where there is internal instability. For example, in the late 1980s NGOs were prominent in Lebanon because of internal instability, but since 1990 when large-scale fighting ceased, their role has diminished. In Palestine the absence of a State, and consequent instability in government has created a situation where NGOs continue to play a major role in the provision of health services.

With the introduction of structural adjustment policies and the withdrawal by third world governments of subsidies and support for health services, cost recovery and fee-for-service systems are gradually replacing previously free services. Insurance schemes cover only employees of institutions providing health insurance. Those outside such umbrella schemes are expected to buy health services directly — which in many instances means doing without any medical consultation.

Mental health resources

According to the World Health Organization (WHO), public expenditure on mental health should not be less than 10% of the total health budget, with 75% of services equally distributed throughout the different regions of the country. Of the total general hospital beds available, 25% should be allocated to mentally ill patients, and the nearest mental health facility should not be more than an hour's drive from potential users. WHO also recommends a ratio of 0.25–1.0 psychiatrist per 10 000 population, and 5–8 mental health beds per 10 000 population [*1*]. The average need for mental health beds has been estimated by WHO for patients with a duration of stay of less than 6 months to be 3.3 beds per 100 000 population, for patients hospitalized from 6 months to 1 year, 1.6 beds per 100 000, for stays of 1–2 years, 1.6 beds, and for 2–3 years, 1.3 beds.

Mental health facilities

The availability of psychiatric hospitals and beds in the different Arab countries is summarized in Table 3. Egypt has about 9000 psychiatric beds, one bed for every 7000 citizens (i.e. 15 beds per 100 000 population). The number of psychiatric beds in Egypt constitutes less than 10% of the total 110 000 hospital beds. The two largest mental hospitals, which accommodate 5000 patients between them, are facing great difficulties regarding care, finances, treatment and rehabilitation [*2*]. The new policy of deinstitutionalization and provision of community care may reduce the number of psychiatric inpatients but will not solve the problem [*3*]. Aftercare services in Egypt are still limited due to generally poor understanding of the need for follow-up care after initial improvement. Community care in the form of hostels, day centres, rehabilitation centres and health visitors is only available in larger cities.

Table 3 **Psychiatric beds and mental hospitals in selected Arab countries**

Country	No. of beds	No. of hospitals
Bahrain	201	1
Egypt	9000	9 state, 9 private
Jordan	560	2 general, 1 military
Lebanon	1800	3 (2 acute units)
Libyan Arab Jamahiriya	1550	2 university hospitals
Palestine	352	2
Saudi Arabia	2000	6
United Arab Emirates	30	1
Yemen, Republic of	570[a]	none

Source: mail survey
[a]Made up of 170 in the general hospital system and 400 in prisons

In Jordan, psychiatric beds are distributed between general hospitals and military hospitals. There are no psychiatric beds in university hospitals. In Palestine, there are two psychiatric hospitals, one in Bethlehem with 320 beds, serving a population of 1 450 000 in the West Bank (0.04 per 1000 population). The psychiatric hospital in Gaza contains 32 beds and serves the population of the Gaza strip (1993 estimated population 800 000). In addition to these two hospitals, Palestinian mental health services include many NGOs, most of which were established during the Palestinian uprising (*intifada*).

In all Arab countries the ratio of psychiatric beds to population leaves much to be desired. The priorities for community health care services in Egypt are not for mental health, but for more endemic health problems, such as malnutrition, parasitic infestations, maternal and child morbidity, and drug abuse. The priority given to these problems is reflected in the allocation of resources for mental health services. Programmes for community care in the larger cities take the form of outpatient clinics, hostels for the elderly, institutions for the mentally retarded and centres for drug abuse, and school and university mental health.

Mental health teams

The number of professionals working in psychiatry is far below that requireded to meet the region's needs. Per capita figures for trained psychiatrists and other mental health personnel in selected Arab countries are given in Table 4. Although the figures are low, public campaigning for psychiatry as a branch of medicine and the greatly increased use of psychotropic drugs, which

Table 4 **Numbers of mental health professionals in selected Arab countries**

Country	Psychiatrists	Psychiatrists per capita	Psychologists	Social workers	Psychiatric nurses
Bahrain	25	–	3	6	67
Egypt	450	1/130 000	211	300	1355
Jordan	60[a]	1/60 000	30	100	100
Lebanon	60	1/45 000	19	38	187
Morocco	140	1/187 142	45	4	250
Palestine	21[b]	1/223 900	6	13	5
Saudi Arabia	181	1/88 950	104	473	1239
Tunisia	100	1/84 000	300[c]		
United Arab Emirates	40	1/62 500	13	30	109
Yemen, Republic of	25	1/500 000	–	–	–

Source: mail survey

[a] *Includes those under training*

[b] *10 trained, 11 under training*

[c] *Total number of psychologists, social workers and psychiatric nurses combined*

are now available to successfully treat previously "incurable" disorders, is gradually reducing the stigma attached to mental illness in the region, and by association, to the mental health profession itself.

Egypt has the highest number of psychiatrists; about 500 — one for every 130 000 citizens (the WHO recommended rate is 1 per 10 000 population), and about 211 clinical psychologists. Hundreds of general psychologists also work in fields unrelated to mental health services. Although there are many social workers practising in all psychiatric facilities, they are for the most part general social workers with minimal graduate training in psychiatric social work. In the 1960s, an attempt was made to train psychiatric social workers at the Institute of Social Services in Cairo. Because of the small number of applicants, the programme was discontinued after 2 years.

Traditional healers

As in the majority of developing countries, mentally ill patients in Arab countries tend to somatize their psychological symptoms. This presentation of mental ill-health reflects on the pattern of consultation. Patients tend to pass through different healthcare-providing filters before reaching the mental health clinic or hospital. Out of every 1000 citizens, 315 have psychiatric symptoms: 230 consult a general practitioner (GP), 101 are identified and diagnosed, 17 are referred to a psychiatrist and only 6 are admitted to hospital [*4*]. The real challenge for mental health professionals is the first filter. Cultural beliefs about possession and the impact of sorcery or the "evil eye" affect people's interpretation of symptoms. In this context the first resort for the families of mentally ill patients is not necessarily a GP, but traditional healers who acquire special importance because of their claim to deal with the "mystical", the "superstitious" and the "unknown". In all Arab countries traditional healers form part of the informal and sometimes unofficial health care sector — a fact easily overlooked. How do they relate to the medical profession in the different contexts? Although there is no interaction between the medical profession and traditional healers in the majority of Arab countries, in Jordan an informal, unorganized relationship does exist, and in Saudi Arabia they constitute part of the mental health staff, using religious texts and recitation in case management. It is interesting to note that people generally differentiate between traditional healing based on religion, and that based on popular belief in ghosts, ginnies and possessions, indicating a potential acceptance of the first and rejection of the second. Traditional healers do, and will continue to, provide some form of intervention in the lives of the mentally ill and their families, particularly where access to mental health services at the community level is limited. Emphasis should therefore be given to the study of the positive and negative impacts of traditional practices.

Mental health legislation

Although Egypt has had a mental health act (MHA) since 1944, many other Arab countries do not have one, or similar legislation specifically dealing with mental health. In Jordan there are two legislative provisions relating to the insane. In Lebanon, Bahrain and Tunisia mental health is dealt with as part of global health legislation. In Bahrain and Morocco specific legislation is being drafted. In Palestine no legislation exists. In the United Arab Emirates (UAE) mental health is covered by ministerial decree

(which has less force than legislation), and in Saudi Arabia the current relationship between doctors and patients is organized according to Shariah (Islamic jurisprudence). A project is underway to regulate the practice of the profession based on the principles of Shariah. In the Libyan Arab Jamahiriya there is no MHA or similar legislation, although the National Committee for Mental Health is preparing a workshop to discuss the need for legislation. Currently, general principles of law are applied to psychiatric patients. In the Republic of Yemen, no specific legislation exists. Most of the existing laws dealing with mental health are old and were written prior to the development of concepts of community psychiatry and integration of mental health into the general health system [5].

The need for mental health legislation is an essential prerequisite for defining the responsibilities and authority of the profession and carer institutions, and for preventing the abuse of mentally ill patients by their families, society and those working within the profession. Mental health legislation should seek to:

- define the minimum responsibilities of government, and the authority, responsibilities and liability of members of the profession;
- specify the role of care givers;
- set out the rights of patients and the means by which these rights are protected, including the right to treatment and patients' individual human rights;
- set out the rights and obligations of the family and the community;
- define the legal basis for service development with the aim of ensuring the patient, family and wider community receive appropriate support in facing the consequences of mental illness;
- provide guidelines for medico-legal purposes such as criminal responsibility and financial affairs;
- ensure the provision of better, more affordable and accessible services;
- provide legal support to activities related to the promotion of mental health and prevention of mental illness, and define the minimum responsibilities of government in these areas;
- provide guidelines for the use of different methods of treatment in order to prevent abuse.

Mental health policy

While all nine Arab countries that responded to the survey question have mental health programmes, only five have a documented mental health policy (Egypt, Bahrain, Republic of Yemen, UAE and Morocco). In the Republic of Yemen, there is a Ministry of Health programme sponsored by WHO which aims to integrate mental health services into primary health care. A 5-year mental health services plan is incorporated in the Ministry of Health's 5-year plan. In Palestine, Libyan Arab Jamahiriya and Tunisia, mental health policy forms part of general health policy. In Jordan, although a draft policy was prepared in 1986, it has still not been implemented — in effect there is no mental health policy [5].

In the absence of such policies, devising strategies for the promotion of mental health is not feasible. This outline of the present status of mental health services in the Arab countries clearly indicates the need for a future strategy for raising the quality of services. The strategy should specifically target the following:

- The development of mental health resources, especially human resources;
- Incorporation of mental health basic sciences into the curricula of medical schools so that students graduating as GPs will have adequate knowledge of mental health problems and their management;
- The development of mental health policies and mental health legislation in those Arab countries where they are inadequate or non-existent, with the aim of creating a unified mental health act;
- Integration of mental health within primary health care and the general health frames of the countries through training of GPs and other health personnel, development of referral and follow-up systems and procedures, such as the provision of essential drugs.

If we can improve, even slightly, the mental health of the 230 patients per 1000 population who present each year to primary care, it will have a much greater impact than the continued treatment of the 5.7 psychiatric inpatients per 1000 population.

A number of general policy principles should guide mental health planning. Policy needs to be based on a decentralized network of services, integration of mental health into general health policy, comprehensiveness of policy outcomes, and equity. People should have equal access to health care: this requires an equitable distribution of resources and possibly, a legislative matrix that promotes the social values and protection of mental patients. The policy should be sustainable. The main element in ensuring sustainability is the participation of the community in its formulation. Community and civil society participation in the formulation of health policy, particularly its mental health policy, is essential to the policy's credibility and support by the target beneficiaries — the patients, their families and the communities in which they live. A mental health policy should target the prevention and treatment of mental disorders and their associated disabilities, ensuring availability of minimal mental health care to the vulnerable and underprivileged. It should employ mental health knowledge to improve general health care and apply mental health principles to improve quality of life [5]. To implement these objectives, the following are required:

- awareness-raising of the population regarding mental health and mental health problems;
- a comprehensive database of mental health morbidity;
- a planned budget;
- training and updating of available human resources;
- generating of new resources and possible redistribution of beds.

Because of very tight budgets and limited availability of resources at this time, as a transitional measure, the best plan for developing countries — this region being no exception — is to train and update GPs to look after chronically ill patients and their families. This will give a better quality service and more lasting support and care than in hostels or day hospitals. There is an abundance of GPs compared to the number of psychiatrists, and as previously mentioned, the greater the knowledge of GPs of mental health, the stronger will be the preference of patients and their families to visit the GP. The natural course of the referral system and the family's supportive role can deliver a better service to mentally ill patients in developing countries than that provided under the present system of community care in the industrialized nations.

Conclusion

The survey revealed an urgent need for all Arab countries to allocate more resources, both human and financial, to the provision of mental health services. Of major concern is the need for an integrated approach by policy-makers, the legislature and judiciary to develop comprehensive mental health policies and legislation which reflect local cultural situations and which respect and protect the human rights of the mentally ill.

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