# Ageing and mental health resources for older persons in the African region of the World Health Organization

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*Abstract.* Africa is a region where a demographic transition from high child mortality and low life expectancy, to low child mortality and high life expectancy is only just beginning. Nevertheless, some countries already have a growing number of persons over the age of 60 – a number that is likely to increase rapidly. As a consequence, the number of older persons with mental disorders is likely to increase. To better understand the organisation of care for older persons, data are being collected to reduce the imbalance between 'disease information' and 'resource information' – information that addresses older persons' needs in terms of mental health care. This review presents some results from the continent. Mental health problems among older adults are still not a public health priority in Africa, but careful examination of each country nevertheless reveals certain specificities, such as divergent life expectancy and different values regarding ageing. The authors present some recommendations for the development of care for old persons with mental disorders, based on the general recommendations made by the World Health Organization (WHO) in the World Health Report 2001 (WHR 2001), and by the WHO and the World Psychiatric Association (WPA) in some consensus statements on psychiatry of the elderly.

Current demographic transitions, which show that the population of several African countries is rapidly ageing, will lead to an increasing number of older persons with mental disorders. These disorders account for a substantial proportion of disease disability and burden; however, current resources for mental health in this age group are invariably inadequate. Both the quality and quantity of mental health resources need to be improved to meet current and future needs. Accurate information on existing resources is part of the process of improving mental health in old age.

To better understand the organisation of care for older persons, statistics are being collected under the auspices of the Atlas project.[1] One goal of this project is to reduce the imbalance between 'disease information' and 'resource information', an imbalance that is a significant impediment in planning mental health services, particularly for older persons (defined as persons >60 years). Lack of information on resources also hampers efforts made by non-governmental organisations (NGOs), professional associations and consumer groups to motivate the improvement of mental health care services and to highlight any needs specific to older persons.

This paper presents some results from the project's African segment. The methodology has been described elsewhere,[1] and some preliminary results have already been presented.[1-4]

## Data and analysis

Preliminary research conducted by the authors[1-4] has already produced the following information, by country:

- demographic distribution: total and >60 years
- life expectancy at birth
- total expenditure on health as a percentage of the gross domestic product (GDP) and the per capita total expenditure on health at the then official exchange rate (both for 2002)
- identification of the NGOs in each country that are active in the field of mental disorders in old age (psychiatry, neurology, geriatrics/gerontology, and consumers of health services).

The first three data groups were taken from the World Health Report 2005.[5] Data concerning the NGOs was obtained from the websites of the World Psychiatric Association,[6] the World Federation of Neurology,[7] the International Association of Gerontology and Geriatrics,[8] and Alzheimer's Disease International.[9]

The World Health Organization (WHO)'s Africa region comprises 46 countries. Some factors in this region that influence the population growth are:

- the low overall density of the population
- a history of having been the major source of slaves, the consequences of which even today are underestimated in the region's demographics and human and economic development

• the presence among the majority of nations of multiethnic groups, with varied cultural traditions regarding marital status, reproduction and regard for the elderly, all of which directly and indirectly influence population health, morbidity, mortality and life expectancy

• the existence of widespread and unresolved conflicts, both international and interethnic, that result in high numbers of victims in terms of mortality, morbidity and migration

• the high prevalence of communicable diseases, including deadly endemic and epidemic disorders.

In 2003, Africa's population was 687 405 000, with approximately 32 639 000 ≥60 years old (4.7% of the total population). While the total figure represents about 10% of the world's population, persons ≥60 represent 5% of the total population.

As shown in Table I, the 3 most populous countries in Africa were Nigeria (124 009 000), Ethiopia (70 678 000) and the Democratic Republic of Congo (52 771 000); together, these countries were home to 36% of the continent's total population and 35% of the total aged ≥60. The countries with the highest proportion of old persons were Mauritius (9.1%), Seychelles (9.1%) and Lesotho (6.9%).

The mean life expectancy at birth in 2003 for the entire region was 49.7 years, the lowest among all WHO regions. Only 5 countries had a life expectancy at birth >60 years: Mauritius (72 years), Seychelles (72), Algeria (70), Cape Verde (70) and Comoros (64). Seven countries had a life expectancy at birth ≤40 years: Swaziland (35 years), Botswana (36), Zimbabwe (37), Lesotho (38), Sierra Leone (38), Zambia (39) and Angola (40). Life expectancy at birth was approximately 2.8 years more for women than men in almost all countries of the region. However, in 3 countries (Botswana, Niger and Zimbabwe), life expectancy at birth was lower for women than men.

Africa is the poorest region in the world. The mean per capita total expenditure on health in 2002 was the equivalent of US$33.80. The countries with the highest health expenditure in the region were Seychelles (US$425), South Africa (US$206) and Botswana (US$171). The mean total expenditure on health as a percentage of the global burden of disease (GBD) for Africa was 5.3%. São Tomé and Príncipe (11.1%), Togo (10.5%) and Malawi (9.8%) invested the most in health in 2002.

A survey culling data from the websites of the World Psychiatric Association,[6] Alzheimer's Disease International (ADI),[9] the International Association of Gerontology and Geriatrics (IAGG)[8] and the World Federation of Neurology (WFN)7 enabled us to conclude that:

• 9 countries had at least 1 national association of psychiatry

• only 1 country (South Africa) had a section addressing psychiatry for the elderly in the national psychiatric association

• 9 countries had an organisation with membership of the ADI

• only South Africa had a national association that is a member of the IAGG

• 4 countries had a national association of neurology.

These results showed that 22% of African countries had at least one association able to represent the interests of professionals concerned with mental health in old age and the elderly themselves, which corresponds with the demographics and conditions of the region. The creation and development of such NGOs is necessary to foster good mental health promotion and care for old people.

## Required actions for mental health in old age

The World Health Organization and the World Psychiatric Association defined psychiatry of the elderly as a branch of psychiatry that addresses concerns related to the psychiatry of people of 'retirement' age and beyond (65 years in general, but this may vary in some countries and according to local practices).[11]

In this context, what should the place of psychiatry of the elderly be in Africa, a region where the proportion of persons >60 years is less than 5% in 57% of the countries, and life expectancy at birth is <65 years in 91.3% of them? Even if we recognise that there are a growing number of older persons in this region, this trend may not justify the development of specific policies, programmes and services for this population. But surely this does not imply that the health authorities can neglect to provide care for older persons – in particular, mental health care?

Consequently, we adopted the WHO general recommendations presented at the WHR 2001,[10] and the WHO/WPA consensus statements of Psychiatry of the Elderly,[11,12] and propose the measures listed in Table II to promote the mental health of old persons in both regions.

## Conclusion

Africa has a low proportion of older persons in its population (4.7% of total population), and a low life expectancy at birth

**Table I. African countries and their total populations; percentage of persons above age 60; total expenditure on health as a percentage of gross domestic product (GDP); per capita total expenditure on health (US$); life expectancy at birth; and presence of a national association of psychiatry, psychiatry of the elderly, geriatrics/gerontology, neurology and Alzheimer's disease**

| Country | Total population 2003 (thousands) | % >60 years 2003 | Total expenditure on health as % of GDP (2002) | Per capita total expenditure on health at average exchange rate (US$) (2002) | Life expectancy at birth 2003 | National association of psychiatry | National association of psychiatry of the elderly | National association related with Alzheimer's disease | National association of geriatrics or gerontology | National association of neurology |
|---|---|---|---|---|---|---|---|---|---|---|
| Algeria | 31 800 | 6.0 | 4.3 | 77 | 70 | Yes | No | No | No | No |
| Angola | 13 625 | 4.3 | 5.0 | 38 | 40 | No | No | No | No | No |
| Benin | 6 736 | 4.1 | 4.7 | 20 | 53 | No | No | No | No | No |
| Botswana | 1 785 | 4.5 | 6.0 | 171 | 36 | No | No | No | No | No |
| Burkina Faso | 13 002 | 4.0 | 4.3 | 11 | 45 | No | No | No | No | No |
| Burundi | 6 825 | 4.3 | 3.0 | 3 | 42 | No | No | No | No | No |
| Cameroon | 16 018 | 5.6 | 4.6 | 31 | 48 | No | No | No | No | No |
| Cape Verde | 463 | 6.1 | 5.0 | 69 | 70 | No | No | No | No | No |
| Central African Republic | 3 865 | 6.1 | 3.9 | 11 | 42 | No | No | No | No | No |
| Chad | 8 598 | 4.8 | 6.5 | 12 | 46 | No | No | No | No | No |
| Comoros | 768 | 4.2 | 2.9 | 10 | 64 | No | No | No | No | No |
| Congo | 3 724 | 4.5 | 2.2 | 18 | 54 | No | No | No | No | No |
| Côte d'Ivoire | 16 631 | 5.2 | 6.2 | 44 | 45 | No | No | No | No | No |
| Democratic Republic of Congo | 52 771 | 4.2 | 4.1 | 4 | 44 | No | No | No | No | No |
| Equatorial Guinea | 494 | 5.9 | 1.8 | 83 | 51 | No | No | No | No | No |
| Eritrea | 4 141 | 3.6 | 5.1 | 8 | 59 | No | No | No | No | No |
| Ethiopia | 70 678 | 4.6 | 5.7 | 5 | 50 | Yes | No | No | No | Yes |
| Gabon | 1 329 | 6.2 | 4.3 | 159 | 58 | No | No | No | No | No |
| Gambia | 1 426 | 5.8 | 7.3 | 18 | 57 | No | No | No | No | No |
| Ghana | 20 922 | 5.2 | 5.6 | 17 | 58 | Yes | No | No | No | No |
| Guinea | 8 480 | 4.6 | 5.8 | 22 | 52 | No | No | No | No | No |
| Guinea-Bissau | 1 493 | 4.8 | 6.3 | 9 | 47 | No | No | No | No | No |
| Kenya | 31 987 | 4.2 | 4.9 | 19 | 50 | Yes | No | No | No | Yes |
| Lesotho | 1 802 | 6.9 | 6.2 | 25 | 38 | No | No | No | No | No |
| Liberia | 3 367 | 3.6 | 2.1 | 4 | 41 | No | No | No | No | No |
| Madagascar | 17 404 | 4.7 | 2.1 | 5 | 57 | No | No | No | No | No |
| Malawi | 12 105 | 5.2 | 9.8 | 14 | 42 | No | No | No | No | No |
| Mali | 13 007 | 3 8 | 4.5 | 12 | 45 | No | No | No | No | No |
| Mauritania | 2 893 | 5.3 | 3.9 | 14 | 51 | No | No | No | No | No |
| Mauritius | 1 221 | 9.1 | 2.9 | 113 | 72 | Yes | No | No | No | No |

**Table I. (continued)**

| Country | Total population 2003 (thousands) | % >60 years 2003 | Total expenditure on health as % of GDP (2002) | Per capita total expenditure on health at average exchange rate (US$) (2002) | Life expectancy at birth 2003 | National association of psychiatry | National association of psychiatry of the elderly | National association related with Alzheimer's disease | National association of geriatrics or gerontology | National association of neurology |
|---|---|---|---|---|---|---|---|---|---|---|
| Mozambique | 18 863 | 5.1 | 5.8 | 11 | 45 | No | No | No | No | No |
| Namibia | 1 987 | 5.7 | 6.7 | 99 | 51 | No | No | No | No | No |
| Niger | 11 972 | 3.2 | 4.0 | 7 | 41 | No | No | No | No | No |
| Nigeria | 124 009 | 4.8 | 4.7 | 19 | 45 | Yes | No | Yes | No | No |
| Rwanda | 8 387 | 4.1 | 5.5 | 11 | 45 | No | No | No | No | No |
| Sao Tome e Principe | 161 | 6.2 | 11.1 | 36 | 59 | No | No | No | No | No |
| Senegal | 10 095 | 4 1 | 5.1 | 27 | 56 | Yes | No | No | No | No |
| Seychelles | 81 | 9.1 | 5.2 | 425 | 72 | No | No | No | No | No |
| Sierra Leone | 4 971 | 4.7 | 2.9 | 6 | 38 | No | No | No | No | No |
| South Africa | 45 026 | 6.3 | 8.7 | 206 | 49 | Yes | Yes | Yes | Yes | Yes |
| Swaziland | 1 077 | 5.2 | 6.0 | 66 | 35 | No | No | No | No | No |
| Tanzania | 36 977 | 3.9 | 4.9 | 13 | 45 | No | No | No | No | No |
| Uganda | 25 827 | 3.9 | 7.4 | 18 | 49 | Yes | No | No | No | Yes |
| Zambia | 10 812 | 4.7 | 5.8 | 20 | 39 | No | No | No | No | No |
| Zimbabwe | 12 891 | 5.2 | 8.5 | 118 | 37 | No | No | Yes | No | No |

(49.7 years). Strong cultural forces affect the growth and ageing processes, and frequent international conflicts cause premature deaths and migrations. The continent's populations are substantially affected by epidemic and endemic communicable disorders. Lastly: poverty, with all the consequences it has upon health, is probably the biggest factor that negatively influences quality of life and life expectancy at birth.

Mental health for all ages should become a priority issue in public agenda throughout the region. It is important to already be able to offer good care to the existing older populations and at the same time be flexible enough to adapt a care system that reflects the specific local needs of each country.

The efforts of national governments to promote mental health should be made according to the principles of organisation of care for old persons with mental disorders,[12] adapted to local resources and cultures. As mental disorders in old age can severely limit the quality of life of older persons and their families, care should be extended to all concerned. The challenge of finding solutions for better living conditions for older people with mental health problems lies in the hands of researchers, policymakers and the broader population. Funding and creativity are two factors necessary to find solutions.

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**Table II. Minimum actions required for mental health care for old persons**

**1. Provide treatment in primary care**

Recognise mental health of old persons as a component of primary care.

Include the recognition and treatment of common mental disorders in old age in training curricula of all health personnel.

Provide refresher training to primary care physicians in contact with old persons.

Develop locally relevant and adapted training materials in psychiatry of the elderly.

**2. Make psychotropic drugs available**

Ensure availability of all essential psychotropic drugs to old persons in all health care settings.

**3. Give care in the community**

Deliver mental health care for older people in the community by personnel specifically trained and working in adapted structures.

Refer patients to an old-age psychiatry service when further opinions and advice are needed and/or for direct specialist care. At least one service of this kind should exist in each country where the proportion of old people in the population becomes significant.

Develop mental health care services to ensure the promotion of mental health and the prevention and early identification of mental disorders. These services should include the assessment, diagnosis and multidisciplinary management of care to people with all kinds of mental disorders in old age.

Organise care services in such a way that they are readily available and accessible to individual patients together with their families and caregivers. These services should be flexibly interlocking, overlapping and integrated to provide a unified system for continuing care and best possible quality of life.

Move old people with mental disorders out of inappropriate institutional settings.

**4. Educate the public**

Public campaigns against stigma and discrimination concerning old people.

Support NGOs in public education on topics concerning old people.

**5. Involve communities, families and consumers**

Promote the formation of self-help groups to support individual patients, together with families and caregivers.

Fund schemes for NGOs and mental health initiatives in the field of psychiatry of the elderly.

**6. Establish national policies, programmes and legislation**

Revise legislation based on current knowledge on human rights considerations concerning old people.

Ensure that mental health programmes and policies sufficiently take into account the mental health needs of old people.

Ensure that the budget for mental health care is sufficient to cover the mental health needs of old people.

**7. Develop human resources**

Train psychiatrists and psychiatric nurses in psychiatry of the elderly.

Ensure that specific topics on psychiatry of the elderly are included in graduate and postgraduate courses for health professionals involved in the care of old persons.

Develop training and resource centres.

**8. Link with other sectors**

Develop programmes to prepare people for retirement.

Ensure that the courts respond appropriately to the needs and rights of old persons.

Develop support for NGOs related to psychiatry of the elderly.

**9. Monitor community mental health**

Include mental disorders in the elderly in basic health information systems.

Survey the specific group of old persons.

**10. Support more research**

Conduct studies in primary health care settings on the prevalence, course, outcome and impact of mental disorders in old people in the community.