experienced delayed onset of such disorders. Fortunately, there is a somewhat more well established research literature regarding effective treatments for mental disorders most likely to result from exposure to mass violence and severe trauma (National Institute of Mental Health, 2002). A number of studies support the efficacy of cognitive–behavioural psychotherapeutic interventions for PTSD, while there is also some empirical support for group and individual psychodynamic therapy. Pharmacotherapy may also provide benefit for people experiencing PTSD, as dysregulation of numerous psychobiological systems is often associated with it. In addition, the high frequency of co-occurring psychiatric disorders among people with PTSD underscores the importance of considering pharmacotherapy in the treatment of PTSD (Foa & International Society for Traumatic Stress Studies, 2000).

Community response

Although the treatments described above are focused on individuals, families and small groups, the need to target interventions at the broader community level should not be overlooked. Activities that focus on bringing together members of the community to provide social and emotional support for persons who have suffered significant losses enhance social cohesion and mutual support, which, in turn, have important health and mental health benefits. As exemplified by New York Mayor Rudolph Giuliani's leadership in the days following 11 September, community resilience is also greatly enhanced by government leaders who can effectively promote a sense of common purpose and optimism even in the face of enormous tragedy.

Finally, it is essential to have an infrastructure in place beforehand if effective mental health interventions are to be delivered following large-scale terrorist events. This includes comprehensive planning for a coordinated response, a well-trained workforce, and greater recognition on the part of government authorities that attending to mental health concerns is a crucial component of public health preparedness in a time of terror.

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THEMATIC PAPER – TERRORISM

Africa: the traumatised continent, a continent with hope

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Many African countries gained political independence in the 1960s and 1970s and went through difficult times in economic, political and security terms in the 1980s and early 1990s. Mental health services and research were not spared and stagnated or deteriorated during this period. The effects of poor governance, inequitable distribution of resources and environmental degradation conspired with natural and man-made disasters (wars in particular) to drive Africa into an abyss of despair.

In East, West, Central and Southern Africa, there is presently fighting over issues that seem unclear even to the combatants. Conflicts, including wars and civil strife,

result in an increase in mental health problems. They place a heavy toll on the already overstretched health and other social services of the region. According to the 2001 *World Health Report* (WHO, 2001), between a third and a half of those affected by conflict suffer mental distress, including post-traumatic stress disorder (PTSD) and depressive and anxiety disorders.

Africa is home to large populations of refugees (approximately 1.5 million) (United Nations High Commissioner for Refugees, 2002) and of survivors of a myriad natural and man-made disasters. Somalia, Ethiopia, Sudan, Rwanda and Congo are examples of countries currently in armed conflict; they provide the region with a large concentration of refugees and internally displaced persons. Psychiatrists in the course of their work come closer to human suffering than workers in many other branches of medicine. For this reason they ought to be more aware of the fact that poverty, and political, social and economic inequalities between groups predispose to conflict (Stewart, 2001).

The embassy bombing

The events of 11 September 2001 have underscored the fragile nature of peace as well as the global inter-dependence of nations. When hijacked planes crashed into the World Trade Center in New York, the theatre of action for terrorism had changed for good. Like many before them, Americans felt the deep sense of loss and violation of the most sacrosanct of their institutions. Important questions were soon to be raised with regard to events in Africa three years earlier.

On 12 August 1998, a fax was received at the Royal College of Psychiatrists from Dr F. G. Njenga, Chairman of the Social Responsibility Committee, Kenya Medical Association, after the bombing of the American embassy in Nairobi. It read:

> You will have heard of the disaster that struck our country in the hands of terrorists. We are about to start the recovery process but we are angry, confused and in some instances drowned by feelings of hopeless-ness…. The Kenya Medical Association (KMA) is now making this appeal to you personally and to your Organisation for any help and/or assistance that you may have either on account of having dealt with disasters of this nature or simply from your experiences. Kindly let us have your views and comments on our appeal at this, our greatest hour of need. (See Alexander, 2001)

Professor David Alexander was sent by the College to Nairobi to respond to the request on its behalf. He later wrote:

> several hours after I had arrived, my hosts took me to the bombsight. Despite my best efforts, nothing I had read nor the photographs I had viewed really prepared me for this sight. In particular, it was hard for me to imagine that the extended pile of rubble was once Ufundi House. Also, the scarred twin 21-storey towers of the Cooperative Bank had not a window left intact.

> On that morning, a one-ton terrorist bomb had exploded during the mid-morning rush hour and killed 253 and injured 5000 people. The destruction to property around the epicentre of the blast was extensive with a number of buildings including the American Embassy completely destroyed. (Alexander, 2001)

To some, Africa was in 1998 a dress rehearsal for New York on 11 September. What lessons did the world learn from the 'Dark Continent'? Did the world take stock of the failures and successes of the Africans? Some think not.

Operation Recovery was a home-grown project that responded to the immediate mental health needs of the Kenyan community. In the six months after the disaster, many questions were asked by Kenyans and remained unanswered. Perhaps more attention to the events of August 1998 could have given clues to the events of 11 September 2001. Why, for example, did the terrorists choose East Africa? What is the relationship between security lapses in 1998 and those of 11 September 2001? At a different level, what were the immediate and long-term mental health needs of those affected? How did Africans respond and what did Americans learn?

A study that followed the bombing in Nairobi involved 2800 subjects; it showed that the bomb injured a young (working) population (mean age 33.8 years), who were mostly married (64%); there were more men involved (54%) than women. Seventy-eight per cent had children and other dependants, and as a group they were the most highly educated Kenyans (76% had had university or secondary school education). Kenyans generally, it turned out, were a highly traumatised group even before the bomb. Of 290 respondents in one study, 98% had suffered one of a number of specified traumatic events, including hospitalisation/surgery, rape, mugging, robbery, loss of a loved one (child or parent), car-jack, internal displacement, harassment by a public authority, or road accident (Kenya Medical Association, 2000). They responded to the bombing of the embassy with marked symptoms of acute stress disorder (86%), as well as obstetric complications (62 of the 67 pregnant women interviewed reported complications). Typical Kenyan methods of coping included prayer and support from the family.

Lessons from Africa

Of all the lessons learnt from Kenya, how many were available to the Americans on 11 September?

Smith *et al* (1990) studied the prevalence of psychiatric disorder following an airplane crash into a hotel and found that more than half the subjects met criteria for a psychiatric disorder after the disaster. Following a similar crash involving flight number KQ103 in Abidjan (Ivory Coast) in 2001, no studies were set up (which underscores the lack of research in developing countries). How, one might ask, could the world benefit from studies in Africa? Shariat *et al* (1999), in a prospective study of the long-term health outcomes among survivors of the Oklahoma City bombing, concluded that a large proportion of survivors of a

terrorist bombing, especially those seriously injured, will experience long-term physical and emotional effects, and have a need for the treatment of bomb-related medical conditions. Four years after the African bombing of the American embassy, no prospective studies are in place – much trauma, no research.

Wider problems

In March 2000, Mozambique suffered the most severe flooding in recorded history. For many hours after the onset of the disaster, the Mozambican Government as well as its neighbours watched helplessly as human lives and property were destroyed. Also in March 2000, the largest mass suicide occurred in Uganda, when nearly 1000 people died. The horror attendant on these tragedies is matched by the absence of a mental health response to attend to the community, the survivors, relatives and rescue workers. The effects of the genocide in Rwanda in 1994 are yet to be studied and understood in full. The long-term psychological effects are unknown.

Most of sub-Saharan Africa is listed by the 2002 *World Development Report* (World Bank, 2002) as existing below the poverty line, while the 2001 *World Health Report* (WHO, 2001) points to the relationship between poverty and mental disorder. Stewart (2001), in an article on the root causes of conflict in developing countries, concludes:

> The sharp economic and social difficulties between western societies and the Muslim world are a clear example of international horizontal inequalities that predispose to conflict.

Other seemingly peripheral issues to be addressed by Africans include poor governance, political instability and high social morbidity due to natural and man-made calamities (including wars). In consequence, Africa has some of the largest numbers of refugees per population in the world. All these factors conspire to give Africans some of the highest levels of independent risk factors for mental disorder of any continent. The story of trauma in Africa makes very depressing reading. Is there reason for hope?

The next part of this paper demonstrates that, hopeless as the picture painted above may seem, there is reason for hope. The project described below is an excellent example of collaboration between Africa and Europe, for the benefit of both.

Mental Health Policy Support Project

Mental health policy is a government's mission statement on mental health and mental health care. As such it represents the formal, written aspirations of the government, which will be implemented, to varying degrees, in the field. The inevitable disparity between policy and practice will vary between countries and between different areas of the same country, depending on the timetable for implementation, on the resources and will for implementation, and on the opportunities and obstacles. The WHO's

collaborating centre at the Institute of Psychiatry, King's College, London, under the directorship of Professor Rachel Jenkins has developed a two-year project, funded by the Department for International Development (DFID) in the UK, to provide mental health policy support to the governments of Tanzania and Kenya.

The goal of the project is to reduce poverty through a reduction of the global burden of mental disorder. Mental health promotion is a multidimensional concept that implies the creation of individual, social and environmental conditions that enable optimal overall psychological development. The project is focused, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes (Hosman & Jane-Liopis, 1999).

The Kenyan component is aimed at building upon the lessons learnt, and at identifying more common issues and lessons that will be used as building blocks for a model that can be replicated in other countries. The main thrust of the project is to evaluate the method of delivery of policy support as a model for DFID's future work in the region, and to make available the findings to the WHO's wider programme on mental health.

The project is implemented through a network of researchers and mental health workers and coordinated by a local project officer in Tanzania and in Kenya.

The main expected project outputs include:
- specific mental health support to Kenya and Tanzania
- the identification of issues unique to each country
- the support of primary care in tackling mental illness
- the establishment of continuing education programmes
- promotion of the use of guidelines
- evaluation of the results of policy support
- the development of a transferable model for policy support for other low-income countries.

The various components of the project are described below.

Country Profile

The Country Profile is an instrument developed by the International Consortium for Mental Health Policy and Services for its project on international mental health policy, programmes and services.

For policy decisions, information on current and future resources is required. Resources are those elements that are injected (input) into the total mental health system in terms of finance, personnel, equipment and buildings. These elements are important and closely related to the types of services provided (Jenkins, 1990; Tansella & Thornicroft, 1998).

The Country Profile gathers the information required to assess the overall mental health situation in a country that is relevant to policy development, in a standardised way, with due regard to sociocultural context. Its main objectives are:
- to provide a database of information about mental health policy, strategy and service
- to facilitate the use of this information to support evidence-based policy development

- to enable comparative analysis between countries, to help identify areas where urgent action is needed and to point to potential solutions
- to provide a common format for the assessment of mental health policy and programmes
- to provide a reference source for United Nations agencies, non-governmental organisations, inter-governmental agencies and for professionals working in the field.

The main work in the development of the Country Profile has now been completed. Kenya has completed the profile and the data are available to the Government and its various divisions to help plan services.

Epidemiological survey

As part of an assessment of the needs of the community, a baseline epidemiological survey using instruments drawn from the British National Mental Health Survey was performed in Maseno division, which has a population of 65 000, situated in Nyanza Province in Kenya. The instruments were translated into the local Dholuo language and primary health care workers administered them and collected the data. The preliminary analysis indicates a prevalence of mental disorder of approximately 11%. The survey is aimed at providing a basis for planning of services at the national level.

Another survey, covering the city of Kisumu, is planned for later in 2003. This will provide information on the urban population. These findings will be compared with those of the British National Mental Health Survey.

Depression attitudes survey

A depression attitudes questionnaire originally used on primary care physicians in the UK was adapted. So far, four surveys to assess attitudes to depression have been conducted. These have been among community health workers, also referred to as village health workers, health workers at a primary care centre (Chulaimbo Health Centre), traditional health practitioners and traditional birth attendants. This will be followed by training sessions based on the responses. A post-training evaluation will be done with a view to making recommendations for wider usage in the rest of the country. Results of the surveys will form the basis for some of the training materials being developed for the second phase of the project. No difficulties were encountered in the translation or administration of the questionnaires to the various groups.

General Health Questionnaire

The 12-item General Health Questionnaire (GHQ) has been administered to patients at a primary care health centre, as they exit after being seen. An analysis of diagnoses and GHQ scores is then done. A training package is planned on that basis for post-training evaluation and eventual recommendation.

Adaptation of WHO primary care guidelines for mental health for Kenya, Tanzania, Zanzibar and Zambia

Through a series of meetings and consultations, various mental health experts drawn from the above countries have reviewed and adapted the guidelines for the specific local conditions and a draft has been produced for distribution to key players in mental health at various levels of care, as per the primary care model.

Conclusion

The joint project is our evidence of hope. The fact that the WHO centre in London, DFID, the Kenyan government, the Kenya Psychiatric Association and the University of Nairobi have come together to run a joint project is reason to hope.

We expect that the Royal College will, through the Board of International Affairs, encourage and facilitate projects of this nature in Africa and other parts of the world.

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