Introduction

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Contributions to the country profile section are welcome: please contact Shekhar Saxena (email saxenas@who.int).

Country profiles provide summary information on mental health policy, services, training and research in the country, along with key references for more details. The aim is to give a bird's eye view of the situation within about 1500 words. It is hoped that this will not only increase the awareness of the readers but also provide an opportunity for learning from others' experiences. The profiles can also open possibilities for further dialogue and even collaboration. This issue of *International Psychiatry* presents country profiles from Ethiopia, Israel and Albania. If you wish to make a contribution to the country profile section, please contact Shekhar Saxena (email saxenas@who.int).

Psychiatry in Ethiopia

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Ethiopia, in the Horn of Africa, is one of the ancient independent nations of the world and has a rich diversity of peoples and cultures. The country covers 1.1 million km² (Central Statistical Authority, 2000*a*). It has a population of about 70 million people (Central Statistical Authority, 2002), 80 different ethnic groups and some 200 dialects. Ethiopia is the second most populous nation in sub-Saharan Africa, after Nigeria (Hailemariam & Kloos, 1993). Forty-eight per cent of the population are under 15 years of age and over 80% live in rural areas (Central Statistical Authority, 1995). Islam and Christianity are the main religions.

The main health problems in Ethiopia are malnutrition and infectious diseases, as has been the case for many years. Life expectancy at birth was recently estimated at 53 years.

Ethiopia maintained its independence during the colonial period. Over the past 30 years the country has undergone several manmade and natural disasters, such as war and political turmoil on the one hand, and famine and drought on the other. A federal system of government is now in place: there are nine regional states in the country and elections take place every 5 years.

Ethiopia is one of the least developed and most agrarian countries in the world; its estimated per capita gross national product in 1998 was $100 (Population Reference Bureau, 2000). About 65% of the country's people live below the absolute poverty line (World Bank, 1994). The literacy rate is estimated to be 38% for males and 23% for females (Central Statistical Authority, 2000*b*).

Health status of the country

The main health problems in Ethiopia are malnutrition and infectious diseases, as has been the case for many years. Life expectancy at birth was recently estimated at 53 years (Ministry of Health, 2002). The crude birth rate is 39.9 per 1000 population per year and the crude death rate is 12.6 per 1000 per year. The infant mortality rate is 112.9 per 1000 live births and the mortality rate for the under-5s is 187.8 per 1000 live births. The maternal mortality rate is estimated at 871.0 per 100 000 live births. Only 28% of the population have access to potable water and 11% to a proper sewerage system. It is estimated that only 60% of the population are able to receive basic health services (Ministry of Health, 2002).

Health policy

The Ministry of Health, which is the government body responsible for organising, running and monitoring health services in the country, was established in 1948.

In 1993, a national health policy and strategy were implemented (Transitional Government of Ethiopia, 1993). The main objective of the policy is to provide people with an acceptable standard of comprehensive primary health care in an integrated, decentralised and equitable fashion. The emphasis is on making health services available to the rural and neglected areas of the country. A four-tier health care system has been adopted. Health centres in the rural areas, each with five satellite health posts each serving 5000 people, form the broad base of the pyramidal system, which progresses up to district, regional and specialised hospitals.

In line with the policy, autonomy has been given to the regional governments to plan, implement and manage health services in the regions through their respective health

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bureaus. The health service has been under-funded, but in recent years its share of government expenditure has increased from below 5% of gross domestic product to 7% (Ministry of Health, 2002).

Mental health services

Ethiopia still remains one of those African countries that do not have a mental health policy, national mental health programme or mental health act (World Health Organization, 2001). Most Ethiopians use traditional methods to treat mental illness and those who do seek to use modern treatments usually do so only after they have tried several traditional means (Alem, 2000).

Families and other concerned individuals are closely involved in the care of people who are mentally ill. However, many families keep relatives with an acute, severe illness at home under restraint (even in chains) until they are no longer aggressive or violent. Once their disruptive behaviour is over, many of these sufferers become vagrants. Not uncommonly such people may be seen walking naked or dishevelled in the streets of villages and towns. They typically receive any sort of care only after they have committed an offence and have been made the subject of a court order (Alem, 2000).

Modern psychiatric services are provided by Amanuel Mental Hospital (the only mental hospital in the country), the out-patient clinic at the University Department of Psychiatry and the psychiatric unit at a military hospital. All these institutions are located in the capital city, Addis Ababa. The military hospital has 30 beds for psychiatric patients. However, until late 1986 there were only two indigenous psychiatrists in the country, one working in the university and the other in the army. In 2003, there were 11 Ethiopian psychiatrists in the country (all of whom had trained abroad): nine working in the above-mentioned institutions and two in private practice. This gives a psychiatrist : population ratio of 1 : 6 000 000.

The Amanuel Mental Hospital was built by the Italians to serve as a general hospital during their occupation of the country in the 1940s. After the Italians left, it was converted to a mental asylum because it was far from the centre and deemed appropriate for the isolation of 'insane' people from the rest of the community. Now, as the city has increased its geographical size, the hospital is no longer on its outskirts but it is still located in an impoverished neighbourhood.

Initially the hospital had very few beds and its prime function was as a place of incarceration for mentally ill offenders. Gradually more buildings were added and the number of beds increased, to the current level of 360, although for many years the hospital accommodated over 500 in-patients. In those days the hospital was run by expatriate psychiatrists from Eastern Europe. From 1984 Ethiopian doctors gradually took over the responsibility for running the hospital and the situation started to change. The number of Ethiopian staff has increased and the patient : bed ratio has become 1 : 1.

The Amanuel Mental Hospital is the only mental health institution in the country to provide a forensic service. However, until hospital beds become available for the close observation and careful examination of alleged offenders by psychiatrists, they stay in the central prison in Addis Ababa. At any given time, one will find about 100 such persons in the central prison awaiting psychiatric assessment (Alem, 2000), sometimes for as long as a year, without any treatment. They are kept in crowded prison cells and are probably maltreated by prison guards and other inmates because of their disruptive behaviour.

The Ethiopian Psychiatric Association was established late in 2002, but formal meetings have not yet begun.

In 1985, the Ministry of Health and the University Department of Psychiatry, in collaboration with the World Health Organization, decided to train psychiatric nurses as the best alternative to provide a primary mental health service in the country. A training programme started in 1987. General nurses are recruited to it from the regional and district hospitals. The training takes one year and is designed to enable the nurses to identify and treat common psychiatric disorders. On completion of the training, the nurses go back to the institution from which they were recruited and set up psychiatric units.

Psychiatrists and general doctors working in psychiatry do most of the teaching of psychiatric nurses. A total of 232 nurses have been trained so far and currently there are 43 psychiatric units in the regional and district hospitals and two health centres outside Addis Ababa, each operated by two psychiatric nurses who graduated from the programme. The nurses receive periodic supervision at their place of work and refresher training by psychiatrists from Addis Ababa. Despite many difficulties, the services run by these nurses are very impressive.

In some regional hospitals the psychiatric nurses are able to admit patients to the medical wards and to provide an in-patient service for them. When they are faced with particularly difficult cases, the psychiatric nurses refer patients to Addis Ababa. After a treatment plan has been decided, the patients are referred back to the psychiatric nurses for follow-up and maintenance treatment. Periodic shortages of the necessary drugs are the greatest problem these nurses face in their practice (Alem, 2000).

Education

For many years Addis Ababa University was the only one in Ethiopia. It had the country's only medical school until 25 years ago, when the Gondar School of Health Sciences started training doctors, followed by the Jima Institute of Health Sciences a few years later.

The teaching of psychiatry to medical students was started in Addis Ababa University in 1966 by Professor Robert Giel from the University of Groningen, The Netherlands, who established a psychiatric unit in the Department of Internal Medicine. Dr Fikre Workneh, the first Ethiopian psychiatrist, came from the USA (where he had trained) and joined the university in 1972. In 1973 the Department of Psychiatry was created and the teaching was done by one person for many years, although expatriate psychiatrists sometimes assisted him. Expatriate psychiatrists also taught psychiatry to medical students at

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the other two medical schools for some time, but for the past 15 years psychiatrists from Addis Ababa are the ones who have done most of the teaching in those institutions.

Since there was no postgraduate training programme for psychiatry in Ethiopia, doctors had to go abroad to do their training. Currently there are five trainees abroad – two in the UK, two in South Africa and one in Russia; they are expected to return to Ethiopia within 1–2 years to practise psychiatry.

In January 2003 the Department of Psychiatry, Faculty of Medicine, Addis Ababa University, started a 3-year postgraduate training programme with a first intake of seven doctors. The department has only three academic staff, all of whom are general adult psychiatrists: one Associate Professor and two Assistant Professors. The department has been able to solicit assistance for the teaching of its postgraduate students from universities and individuals abroad. The Department of Psychiatry at the University of Toronto, Canada, has committed itself to assisting the programme by sending two teachers for three 1-month blocks every year for 3 years. This is part of the University of Toronto's commitment to developing international partnerships for collaborative education and research. In addition to the Toronto-based faculty teaching in Ethiopia, psychiatrists from the University of Addis Ababa will visit Toronto to present research papers and to teach. The programme is also an opportunity to share expertise in mental health service delivery, research and education, and advocacy for mental health issues in both countries.

Volunteers from The Netherlands, England, Australia, Sweden and the USA also have contributed greatly in the postgraduate training programme, which is proving a success. More institutional collaborations are being sought to strengthen the programme until the department becomes self-sufficient.

External funding sources and collaboration with universities abroad have contributed greatly to mental health research in Ethiopia.

Research

Despite the facts that the number of psychiatrists in Ethiopia has always been minimal, the resources are limited and the infrastructure is poorly developed, quite a few research papers have been published in international and local journals since the 1960s. Particularly over the past 10 years, mental health research in the country has changed significantly. Epidemiological studies in different population groups such as children, adults, islanders, semi-nomads, displaced people and women have been conducted in towns and rural settings. Some of these studies are ongoing. For example, a cohort of patients with schizophrenia and bipolar disorder is being followed in Butajira District, a rural setting, to describe the course and outcome of these disorders, which is one of the few such studies in the world in these settings (Kebede *et al*, 2003). A good number of publications have appeared in international and local journals from these studies. External funding sources and collaboration with universities abroad have contributed greatly to mental health research in Ethiopia.

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COUNTRY PROFILE

Mental health services in Israel

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Israel is a multicultural society in a state of permanent change. The population, of about 6.5 million, comprises the following religious groupings: Jews (77.5%), Muslims (15.3%), Christians (2.1%), Druzes (1.7%) and others (3.4%). The organisation of and the approaches used by the country's health services have been determined by this socio-cultural plurality, and also by a continuous influx of immigrants (among whom, 882 600 and 44 200 arrived from countries of the former USSR and Ethiopia, respectively, between 1990 and 2001), as well as by the precarious security situation (the country has seen several wars with its neighbours in addition to the long-standing conflict with

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