

Focus on psychiatry in East Africa

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East Africa is made up of Kenya, Uganda and Tanzania, all previous colonies of the British Empire which attained their independence in the early 1960s. At the time of independence, the East African community held the three countries together. Political expedience broke up the community in 1977 but greater wisdom and economic reality have brought the three countries back together in December 2001, in the form of a common Legislative Assembly and Court of Appeal. A Customs Union is expected soon, ahead of full political integration.

Geographically, the three countries surround the second largest freshwater lake in the world, Lake Victoria. They can be treated as one system for the purpose of this discussion but, as will become evident, the three developed in distinctly different ways following political independence. Kenya embraced a strict capitalist market-driven economy, Tanzania committed itself to a socialist system of government called *Ujamaa*, while Uganda experimented with rapidly changing and increasingly violent political systems. In recent times, the three have once again discovered commonality in being home to 1.5 million refugees from all the surrounding countries, namely Somalia, Sudan, Ethiopia, Burundi, Congo, Malawi and Mozambique.

Their mental health services have, however, remained united in their apparent refusal to improve. A visit to the famous mental hospitals, Muhimbili (Tanzania), Butabika (Uganda) and Mathari (Kenya), in the late 1960s and early 1970s told the same story of neglected, dilapidated, overcrowded asylums located far from the centre of the city; areas not to be visited by those with any medical authority. Many of the patients spent years in these institutions, never visited by psychiatrists or relatives and often receiving chlorpromazine or barbiturates (when available) for sedation.

All three hospitals had overworked and underpaid dedicated nurses who

lived among their patients as their own relatives.

Changing political fortunes in East Africa (i.e. democracy) have led to greater liberty for persons with mental disorders, as is evidenced at Butabika and Mathari Hospitals. East Africans with mental disorders are waking up to a new dawn, in which their hospitals are the focus of attention by their governments, and they are seeing unprecedented improvements. The asylums are now visited by 'big people', who have noticed their filth and squalor. The hospitals have budgets set aside for them and, to the surprise of all, merely by giving patients psychotropics, most have managed to discharge many of their long-stay populations.

Uganda is the leading example. It has attracted primary health care activities such as immunisation and other maternal and child health clinics to the mental hospital. The hospital has become home to community activity. This has had an interesting benefit on the stigma campaign, as more people have come face to face with the discovery that mental illness is treatable.

HISTORICAL PERSPECTIVE

It is now known that an indigenous system of medicine existed in many African countries. Also, it is common knowledge that in Eastern Africa certain herbs were used by traditional medicine men in the treatment of 'insanity' and epilepsy, and even a form of surgery known as *Kisii* craniotomy was performed by the Abagusii people in Kenya.

Kenya became a British colony in 1895 and for the following seven decades strictly adhered to British colonial medical practice.

The only mental hospital in Kenya for many years was Mathari Hospital, which has existed since 1910, operating under various titles. Initially, it served the pressing needs of the colonial armed forces by

admitting the 'mad' soldiers during the First and Second World Wars. Although no written records exist of its earlier days, it is known that a smallpox isolation centre, then some distance from Nairobi, was converted into Nairobi Lunatic Asylum. During the First World War, the asylum admitted patients from various colonial African troops who fought for Britain on the continent. It is an interesting observation that the first patient died in 1970 without ever having left the hospital.

As was the practice in the colonies, the Africans – the 'native lunatics' – lived in the 'bomas' (a term used for livestock stockades). The 'natives', who formed more than 95% of the inmates, endured the poorest conditions and invariably lived in grossly overcrowded bomas. However, slightly better facilities were available to the Indians while, by Kenyan standards, the best wards, food and other amenities were reserved for the Europeans. Until 1963 and for a short period thereafter, psychiatrists, senior doctors and nurses deployed at Mathari were all Europeans. There were no qualified Kenyan psychiatrists at all at the time of the country's independence.

Tanzania

In Tanzania, mental illness was historically considered an incurable curse. People feared and rejected people with mental illness. They often resorted to witchcraft and traditional healers to remove the curses or supernatural forces behind the illness.

The first mental hospitals were set up under European rule, first by the Germans in the late 1890s and then by the British in 1935. In the 1960s and 1970s, more regional psychiatric units were established around the country in an effort to take the services closer to the people. It was also intended that each region would have a rehabilitation village and a few were built. However, there was no systematic outline of the country's mental health policy.

The Tanzanian National Mental Health Programme was developed in the late 1970s by the Ministry of Health, supported by the World Health Organization (WHO) and the Danish Development Agency (Danida), and initiated in 1981 in two pilot regions with the objective of decentralising care. Mental health care provision was conceived as a sub-system within the general health care system, and teamwork and integration with general health care was emphasised. The rehabilitation villages provided

training for patients in such skills such as farming, animal husbandry, carpentry and sewing. The decentralisation of health services was facilitated by Tanzania's socialist philosophy of *Ujamaa*.

Psychiatrists

Tanzania has a population of 30 million. In 1998, there were 14 psychiatrists in the country. By 2001, this had declined to 10 psychiatrists working in the public sector, of whom 4 are at Muhimbili (the main teaching and referral hospital).

Traditional healers

The Ministry of Health has a section for traditional medicine. Traditional healers are becoming less common in the rural areas but are available in the cities (where they presumably can make more money but may be less well apprenticed). Also, the herbs they use are becoming less available apart from in a few areas of natural forest. Christian missionary activity has also done much damage to traditional healing.

Training of mental health workers

In the undergraduate training course, there is a mental health module in each of the five years. The three-year postgraduate training course suffers the classical problem of small departments – an enclosed community. The department welcomes visitors to widen views and experiences in this, the only psychiatric training facility in Tanzania.

Uganda

Uganda is the cradle of medicine in East Africa. In pre-independence days, Makerere University was the seat of medical excellence. John Cox, Allan German and John Orley are but a few of the established psychiatrists who carried out landmark research here.

John Orley not only lived among the Baganda but learned to speak their language fluently. In his masterly monograph co-written with John Wing (Orley & Wing, 1979), he made vital contributions to the understanding of the Bagandan concept of mental illness and their approach, classification, etc.

Kagwa (1964) and Muhangi (1973) of the Makerere Medical School studied the problems of mass hysteria in East Africa. They found that such epidemics occurred commonly in schoolgirls and the symptoms had very strong cultural colouring. People

in the traditional society suspected supernatural powers or food when several children were affected and sought the help of the traditional healers. In another paper, Kagwa (1965) wrote about the pattern of mental illness. He noted that schizophrenia, organic and transient psychoses were frequently seen among admissions to psychiatric wards.

Following independence and in the dark days of consecutive dictatorial regimes, Uganda lost most of its leading doctors. Some migrated to Kenya and helped set up the medical school there while others scattered in Europe and America. A number of the great names of medicine were killed as Uganda entered the darkest hour of her history.

Some of the most remarkable changes in East Africa have, however, taken place recently in Uganda, evidenced by the transformation of Butabika hospital from the traditional, large, neglected mental asylum of yesteryear to a beautifully painted and maintained hospital serving the mental health needs of the local community as well as its primary health care needs. This has been achieved by the creative use of available resources as well as by dynamic, merit-based leadership. Makerere is showing definite signs of reclaiming her lost glory, with the re-establishment of a vibrant medical school, and a well-managed postgraduate training programme in psychiatry. Mental health is an integral part of its primary health care policy.

Kenya

Kenya has a population of approximately 30 million. It has 5500 doctors of whom 47 are practising psychiatry. Half of this number practise in Nairobi, with a population of 3 million, leaving the rest of the country to share 25 psychiatrists. Kenya is, none the less, one of the best served countries in African psychiatry.

Mathari Hospital is the national referral and teaching hospital and the official capacity is 750 beds (1500 before decentralisation). There are two wings: the civil wing for ordinary patients and a maximum security unit for mentally disordered offenders who have committed a capital offence and for other mentally disordered offenders referred for assessment and treatment within the criminal justice system. It is a rich source of research on cross-cultural issues. Special clinics for children and adolescents are run at the Kenyatta National Teaching

Hospital. There is a vibrant private sector in psychiatry providing services to the middle-class and expatriate community and supported by a rapidly growing health insurance system.

Mental health legislation

In 1933, the British Government took the Indian Mental Health Act and applied it to Kenya. In 1949, the colonial parliament enacted a law, the Mental Treatment Act, based on a prototype borrowed from Britain. This Act determined how patients were treated. In 1959, the Mental Treatment Act was replaced with a more humane Mental Health Act, which placed emphasis on community mental health services, repeating the spirit of the new Act in Britain.

The current Mental Health Act came into operation in 1989 and for the first time provides for the voluntary treatment of people with mental illness. It also creates a regulatory board to oversee its implementation. The introduction of new legislation in Kenya points to the significance of changing laws regarding the care of people with mental illness. As with other sub-Saharan countries, the economic crisis and increasing urbanisation in Kenya have led to a situation in which people are threatened with neglect or abandonment. While its neighbours are trying to tackle similar problems, Kenya has gone the furthest in implementing new legislation. Whereas the former legislation only covered the handling of patients with mental illness (e.g. their hospitalisation, discharge, repatriation and the management of their property), the new legislation is also concerned with efforts to decriminalise, demystify and destigmatise mental illness. It is concerned with making mental health care more 'communal' and less centralised, simplifying admissions and integrating mental health services within the nation's general governmental services.

As a result of the 1989 Mental Health Act, over half of all government general hospitals opened their doors to psychiatric patients. Psychiatric nurses were deployed equitably in general hospitals around the country; general medical officers became involved in mental health care; out-patient mental health clinics were set up in general hospitals; and some outreach services were established. In addition, the Kenya Board of Mental Health has begun to meet regularly; regulations for the administration of

the Act have been formulated; and financial provision adjustments continue to be made.

Psychiatric education

In 1968, Nairobi University founded a School of Medicine and the Department of Psychiatry became part of this in 1971. It mainly taught behavioural sciences and psychiatry to undergraduate medical students. The second medical school opened in 1990 at the Moi University. The first indigenous Kenyan qualified in psychiatry in 1970 from the UK and 5 years later, formal arrangements were made with the University of London under which four places were held for Kenyans to study in the UK each year. (This author is a beneficiary of that scheme.) It was not until 1982 that the Department of Psychiatry in Nairobi University started training psychiatrists. The academic Department of Psychiatry currently has eight psychiatrists, one clinical psychologist and one psychiatric social worker. It serves the training needs of both undergraduate and postgraduate trainees and services other training institutions such as the School of Nursing. It is also involved in educating the public and serves other countries in the Eastern African region. An MSc in clinical psychology programme was started recently and is a first in Kenya. Another programme begun recently is a diploma in psychiatric trauma, intended to train medical workers to respond to the many trauma presentations in Kenya.

REVIEW OF EARLIER LITERATURE IN EAST AFRICA

Smartt (1956) appears to have been one of the few earlier colonial psychiatrists who did not share the then prevailing view that the African generally showed some 'psychopathic' personality characteristics. Commenting on this controversial issue, Smartt stated: 'The personality traits in the African which appear psychopathic to the European may be due to the African simply lacking the physical means of monitoring behaviour . . .'. He concludes his lengthy paper with a warning that, 'There is no reason to suppose that the European does not appear equally psychopathic through the eyes of a rural African in the bush!'

A notable publication was on mental disorders in primary health care (WHO, 1973). The WHO collaboration study was aimed at estimating the frequency of

psychiatric disorders at primary health care level. It was also intended to assess the extent to which psychiatric morbidity is correctly identified by primary health workers.

This multi-continental survey, involving various cultures, found that 15% or more primary health care attendees had a psychiatric disorder and they often presented themselves at the primary health clinic. However, in most instances they are not identified as 'psychiatric cases' by the clinic staff. It also confirmed that psychiatric disorders manifest themselves with somatic complaints and receive only symptomatic treatment. It appears that research on the relationship between culture and mental illness had become a topic of interest. Gordon (1936) expressed his views on this subject in an address entitled, 'An inquiry into the correlation of civilization and mental disorder in the Kenyan native'. The focus of enquiry had been the claim that 'primitive' societies are protected by the traditional social and cultural values and that the incidence of mental illness would rise with progressive westernisation of the natives. Gordon feared that adolescent disorders would rise steeply in years to come and proved his point by demonstrating that the educated African had a greater susceptibility to mental illness. There is some support for this fear. Depression seems more prevalent among the educated middle classes in East Africa (although no systematic studies have been done to establish this).

Although it is difficult to agree with some of Carothers's (1951) findings, the quality of his work was remarkably high. In support of his arguments, he cites 33 examples of African behaviour based on his observations and states that 'the African seldom uses his cortex'. Absence of depression is also attributed to the latter cause. The debate raged on in scientific circles and was, according to recently available evidence, used by the colonial government to 'prove' that those Africans agitating for independence were psychopathic. This is an interesting instance of the abuse of psychiatry.

Assessing the arguments generated by Carothers's papers, Lambo (1956) observed:

'The controversy that inevitably ensues illustrates the unfortunate effect on science of the moral arrogance of nineteenth and twentieth century Europe, which sets up its civilization as the standard by which all the other civilizations are to be measured.'

Sir Aubrey Lewis (1961) also addressed this issue. He wrote:

'This seems to me a fallacy proceeding from unsound premises, and leading to a *reductio ad absurdum*. There is no convincing evidence that the aetiology and pathology (including psychopathology) of the varieties of mental disorder is different in Africans from what it is in Europeans, or that the incidence is grossly different, or that very diverse traditions, religious and social institutions had more than pathoplastic influence on the manifestations of mental illness.'

In his paper on psychiatry in sub-Saharan Africa, German (1972) considered the findings of earlier low prevalence rates as 'meaningless and they reflect paucity of psychiatric diagnostic facilities, communications and basic health services'. One is forced to agree with his findings as all subsequent studies have found prevalence rates of psychiatric disorder to be similar to those found in the West.

FACTORS INFLUENCING THE MENTAL HEALTH OF EAST AFRICANS

Poverty

East Africans are some of the poorest people in the world (Table 1). The World Bank (2002) ranks Kenya-Uganda-Tanzania among the poorest countries in the world. According to the World Health Report 2001 (WHO, 2001), 'Poverty and associated conditions of unemployment, low educational level, deprivation and homelessness are not only widespread in poor countries, but also affect a sizeable minority of rich countries. Data from cross-national surveys show that common mental disorders are about twice as frequent among the poor as among the rich'. Depression is more common in the poor than in the rich.

Conflicts and disasters

The events of 11 September 2001 have underscored the fragile nature both of peace and of the global interdependence of nations. No country can claim to be peaceful when its neighbour (in a global sense) is suffering. Eight of the world's poorest countries are suffering or have recently suffered from large-scale violent conflict.

Psychiatrists, because of their special position in society, come closer to human suffering than any other branch of medicine. They ought to be more aware than others of the fact that poverty and

Table 1 Comparison of some key demographic, socio-economic and psychiatric parameters between the UK and East African nations

Country	Population (millions)	Psychiatrists (n)	Life expectancy at birth (years)	Under-5 mortality (per 1000)	Adult illiteracy (% of people aged 15 and above)	Population below poverty line (%)	Population living below US\$1 a day (%)	Gross domestic product (US\$ millions)
UK	60	8082	77	6	0	0	0	1 413 432
Kenya	30	47	48	118	19	42	26.5	10 410
Uganda	22	8	42	162	34	35.2	?	6248
Tanzania	34	10	45	152	25	51.1	19.9	9316

Source: World Bank (2002).

All the East African countries are classified as low-income countries.

All have life expectancies below 50 years and infant mortality rates in excess of 10%.

Half of Tanzania lives below the poverty line. There is one psychiatrist to 2 million in Tanzania.

political, social and economic inequalities between groups predispose to conflict. Psychiatrists in East Africa and the rest of the continent must get involved in policies to tackle these problems as they directly contribute to psychiatric morbidity by increasing poverty and large-scale displacement of populations. The greater (global) psychiatric community has the moral duty to help. Some understanding of politics is mandatory for psychiatrists.

For example, conflict is greater in semi-democracies or governments in transition (like East Africa) and democratic institutions must be inclusive at all levels – for example, voting systems should ensure that all major groups are represented in governments (Stewart, 2002). These are issues that were, until recently, foreign to psychiatric literature. These are the real issues in East Africa, the home of millions of refugees.

East Africa is home to approximately 1.5 million refugees (see <http://www.unhcr.org>), and survivors of myriad natural and man-made disasters. Somalia, Ethiopia, Sudan, Rwanda and Congo are the neighbours who are currently in armed conflict and provide the region with a large concentration of refugees and internally displaced persons. Conflicts, including wars and civil strife, result in an increase in mental problems. These situations place a heavy burden on the already overstretched health and other social services of the region. According to the WHO (2001), between a third and a half of those affected suffer mental distress, including post-traumatic stress disorder (PTSD), depressive and anxiety disorders.

The majority of refugees and internal migrants lack services that can attend to their mental health needs. Services must therefore be developed that help health care workers

to identify and treat mental distress among dislocated peoples. To identify the mental health needs of refugees and other dislocated peoples, culturally sensitive mental health assessments need to be developed and used. Since it is unrealistic to provide individual therapy to the majority of refugees, community work programmes must be consistently implemented in refugee settings as the first therapeutic option. Programmes that deal with the trauma of political violence must also be systematically employed in refugee camps. Opportunities exist for the study of the causes, consequences and prevention of conflict in the region. Poverty and inequitable distribution of resources has recently been identified as a major cause of conflict (see *BMJ*, special issue 9 February 2002).

AIDS

HIV is spreading very rapidly in many parts of the world. In 16 countries of sub-Saharan Africa more than 10% of the population of reproductive age is now infected with HIV (WHO, 2001). The HIV/AIDS epidemics have lowered economic growth and are reducing life expectancy by up to 50% in the hardest-hit countries. In many countries, HIV/AIDS is now considered a threat to national security.

The mental health consequences of these epidemics are substantial. A proportion of individuals suffer psychological consequences (disorders as well as problems) as a result of their infection. The effects of intense stigma and discrimination against people with HIV/AIDS also play a major role in psychological stress. In addition, family members also suffer the consequences of stigma and, later, of the premature deaths of their infected family members. The

psychological effects on members of broken families and on children orphaned by AIDS have not been studied in any detail, but are likely to be substantial. There is a need for further research in this area (WHO, 2001).

RECENT LITERATURE

East Africa went through difficult times in economic, political and security terms in the 1980s and early 1990s. Mental health services and research were not spared. The effects of poor governance, inequitable distribution of resources and environmental degradation conspired with natural and man-made disasters (wars in particular) to drive East Africa into an abyss of despair.

Makerere, then the premier research and training institution, suffered the wrath of dictatorial regimes while Tanzania, under President Nyerere, experimented with a brand of socialism that failed. Corruption, poor governance and insecurity characterised the Kenyan scene and East Africans sank into greater depths of poverty and insecurity. In spite of this gloomy political situation, the University of Nairobi continued to run a vibrant postgraduate programme in psychiatry out of which came some interesting research. Acuda (1983) reviewed the mental health problems of Kenyans and concluded, 'despite a growing awareness in the country that the mental health problem is quite prevalent, very little research has been done to date to confirm these observations'.

Alcoholism was identified from an early stage as a serious problem in Kenya (Bittah & Acuda, 1979) who stated: 'Concern about the increasing use of alcohol in Kenya has been repeatedly expressed and this has been supported by several studies,

which have shown a high prevalence both in rural and urban areas'. Alarm bells were sounded in specific groups, including children (Njenga & Acuda, 1982). They concluded: 'While the prevalence of depressive illness in children in this country remains unknown, these cases indicate strongly that the illness does exist and that many cases may go unrecognized'.

Those in prison services have also been the subject of concern. Muluka & Acuda (1978) stated: 'Where such examinations were made, over 95% of the criminals were seriously mentally ill'. But interesting questions also arose: 'Where are the psychopaths? There was not a single case of psychopathic personality disorder although this is the one psychiatric disorder that is most commonly associated with criminal behaviour'.

The problem of drug use in adolescence continues to grow in East Africa. Dhadphale *et al* (1982) studied the problem among 4450 adolescents in urban, peri-urban and rural schools and found 10% of the students drank alcohol more than three times a week. They concluded: 'The use and abuse of drugs, especially cannabis and alcohol by Kenyan school children seems to be widespread and on the increase'.

Cox (1979; 1983) studied another special needs category, antenatal mothers. He found: 'The separated Ugandan mothers were more at risk of antenatal psychiatric disorder. Ugandan women lost to follow-up were more likely to have experienced psychiatric symptoms during pregnancy, to be living alone, and to have attended late in pregnancy'.

There is ample evidence from the published East African literature that much work needs to be done for these special groups. Very little is going on at the present time, and there is much room for collaborative research in the region.

REGIONAL MEETINGS

In 1996, Professor Norman Sartorius, then President of the World Psychiatric Association, challenged a group of East Africans to start a regional initiative to bring back scientific and cultural exchange. Kenya took up the challenge and in 1998 played host to regional psychiatrists. Annual meetings have taken place since, in Kampala and Nairobi. In 2001, the meeting was opened by Dr Gro Bruntland (Director General, WHO) and attracted participation from seven countries in this region. The World

Psychiatric Association is a keen supporter of the regional initiative and Professor John Cox, past President of the Royal College of Psychiatrists, has indicated his intention to participate at a regional meeting in the near future.

The regional psychiatric associations are keen to host colleagues from other countries who have the courage and conviction to visit and share with fellow psychiatrists.

COLLABORATIVE EFFORTS

A number of projects are currently underway between the WHO regional office for Europe and the governments of Kenya and Tanzania. The first involves the development of health care guidelines for primary health care workers. Since 20–30% of those attending primary health facilities suffer primarily from psychiatric disorder (Ndeti & Muhangi, 1979) this project is justified. In a recent study (Othieno *et al*, 2001), Kenyan doctors have indicated their own need for further training in psychiatry.

A second project is intended to assist the East African states to develop a profile of their social and demographic data to aid in the formulation of a mental health policy. To this end, population surveys similar to the UK's household survey are currently taking place in rural Kenya and Tanzania. The Kenyan project is coordinated by the Kenya Psychiatric Association.

Research

Opportunities for collaborative research exist in many areas. The debate on the role of perinatal complications and psychosis (schizophrenia) continues. Because of the high rate of obstetric complications in East Africa, a fertile ground exists for research into this complex area. Equally, the prevalence of Alzheimer's disease in East Africa is unknown. What could we learn from prevalence studies? Psychological trauma in East Africa is so common as to be considered 'normal'. Eighty per cent of Kenyans respond to trauma with prayer. What is the significance of this? What are the prevalence rates of PTSD following different types of trauma. What would we learn about the biology of PTSD from such studies? There is much speculation as to the different rates of drug metabolism between the races – what is the role of race and what is the role of sub-clinical malnutrition? Why do Africans so rarely

suffer from anorexia nervosa and obsessive-compulsive disorders?

Working with English-speaking East Africans with a solid British commonwealth-based education presents many opportunities for the advancement of science and for helping East Africans gain their rightful place in 21st-century psychiatry.

MEDIA ACTIVITIES

One of the definite advantages of being a psychiatrist in East Africa is the esteem in which one is held by the media. Kenyan and Ugandan psychiatrists have regular and beneficial radio and television programmes and the print media carry frequent features and columns authored by psychiatrists. These contacts have proved invaluable in times of national crisis like the American Embassy bombing in Nairobi (1998) and the Kanungu cult mass murders in Uganda (2000) where approximately 1000 people died. They are also powerful instruments of public education and in the fight against stigma. I have a weekly television talk show (*Frankly Speaking*) in which patients, their families and other consumers of mental health services speak openly about their experiences of mental disorder. This programme has proved to be a very popular method of destigmatising mental illness, as Kenyans see first hand, and to their great surprise, persons who have suffered suicidal depression and/or psychosis discuss without fear their route to recovery. The most powerful message here, which is new in East Africa, is that patients can get better, can look 'normal' and have no shame about having suffered a mental illness. This, coupled with discussion by members of the families about the problems they may have encountered and the ways they dealt with them, makes this approach to stigma reduction very popular.

A weekly phone-in (radio) programme is equally dedicated to mental health and is also very popular.

INTERNATIONAL PRESENCE (ABSENCE?)

Patel & Sumathipala (2001), in a survey of six leading journals, found 'Of the six leading international psychiatric journals, over 90% of all the literature is derived from Euro-American societies. Africa

contributed 11% of the 6% contributed by countries other than Euro-American states'.

No mention is made of East Africa. Poor quality of submitted manuscripts is cited as one reason for the poor presence of the developing world in the leading journals. East Africans are prepared to learn how to present good-quality manuscripts if that is what it takes for the world to learn what we have to offer.

Their second recommendation is worth repeating, in this regard: 'It may be possible to consider editorial styles which are collaborative, so that important papers are not rejected for purely style or language reasons'. Leff, in his response to the same article, states categorically that while he and Edward Hare were editors of the *British Journal of Psychiatry*, 'Considerable effort has always been directed at this problem to the extent sometimes of an editor completely rewriting a manuscript in which the text was difficult to understand'. There is hope for East Africans and the world and this fact should be better publicised to all. Andrew Cheng (2001) sums it all up, 'In order to improve the situation, we need to facilitate mutually beneficial good quality international collaborative research between East and West (and North and South!)'. There is much to be learnt from this approach.

CONCLUSION

East Africa is a land of opportunity for those interested in visiting the cradle of mankind, sandy beaches, tropical forests with mountain gorillas in Uganda; deserts in Northern Kenya; Lake Victoria, the source of the Nile, and the eighth wonder of the world, the Ngorongoro Crater, in Tanzania; or snow on the equator on Mount Kenya. For those inclined to do a psychiatric safari, opportunities exist for

collaborative research in the now vibrant academic centres of East Africa, visits to traditional medical practices of healing or, at the very worst, a visit to the homes of old boys (and girls) who trained in Europe with some of the readers of this *Journal*. Bring along your old books, journals, computers and even seminar and tutorial materials and they will be received with eternal gratitude. In return, East Africans have hospitality skills that are now legendary and often some form of accommodation can be arranged in exchange for seminars and lectures. Welcome to East Africa.

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