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Editorial

Defeating Depression in the Developing World: A Zimbabwean Model

One country's response to the challenge

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Although early authors emphasised the rarity of depression in certain Third World settings, a number of studies over the past 20 years have shown that depression is as frequent, and probably more common, in parts of Africa as it is in Camberwell or North America (Leighton *et al*, 1963; Orley & Wing, 1979; Hollifield *et al*, 1990). In addition, Marsella *et al* (1985) and Kleinman (1991), among others, have written of the rise in depression across both richer and poorer regions, citing such reasons as urbanisation, economic depression and the breakdown of traditional family structure.

World Bank Development Report 1993

In many areas of the world, these figures have hitherto been primarily of academic interest, the pressure to counteract infectious disease and perinatal mortality having consumed the bulk of health budgets. Ministers will, however, take notice of the World Bank Development Report 1993 which, having the theme of "Investing in Health", was published in collaboration with the World Health Organization (World Bank, 1993). The burden of communicable and non-communicable disorders was measured using disability-adjusted life years. (A disability-adjusted life year considers both the estimated severity of the disability caused by a particular disease and the number of years of healthy life lost as a result.) Within the non-communicable group, the psychiatric and neurological illnesses such as depression, alcohol dependence, epilepsy and the dementias, came second only to cardiovascular disease as the major cause of disability across both developed and developing regions. A 'top-ten list', drawn from the full range of communicable and non-communicable disorders, was then compiled, of conditions considered priorities for intervention. This took into account not only whether the disease in question was causing great burden, but also if it was thought to be controllable through a moderately cost-effective intervention. Depression was thus ranked as the fifth priority for health intervention in women aged 15–44 years, and the seventh in men.

Given the myriad problems faced by many non-industrialised countries, how might policy makers respond to such conclusions? One developing country which has recently taken up this challenge is Zimbabwe.

A Zimbabwean model

Health workers' observations

In the Harare City Health Department, general nurses – the frontline primary health care workers – identified patients coming with aches and pains who scored highly on a screen for psychological symptoms (Harare City Health Department, 1990). Although their impression was that a number of these patients were 'depressed', the nurses felt unsure of how to make a diagnosis; neither did they have the confidence to carry out counselling or to prescribe antidepressants at effective doses.

Collaborative research

A project was set up between the Harare City Health Department and the University of Zimbabwe Medical School. Local terminology for depression and ideas on treatment were established through interviewing traditional healers and key community figures. This was elaborated on thorough assessment of a random community sample of women and a sample of clinic attenders (Broadhead & Abas, 1994*a*). Depressed patients were found to be presenting with multiple physical symptoms, especially various pains, dizziness and weakness. Two prominent complaints, accompanied by a mixture of sleep loss, sadness and loss of interest, were "thinking too much" or, in Shona, "kufungisisa", and a "painful heavy heart", "mwoyo unorwadza". These two complaints implied "the carrying of an insoluble problem" and, together, seemed to encapsulate the syndrome of depression. The social origins of depression in women were predominantly related to maltreatment by husbands and by in-laws, to deaths, and to having to care for someone with physical illness, rather than to pure economic and housing difficulties.

Community workshop

At a meeting, health workers presented the research results to members of the community. Participants

then divided into focused discussion groups. Recommendations were generated for short- and long-term implementation on the education and training required for depression and suicide, and on approaches to prevention and treatment at community, local service and national level. These ranged from practical ideas about changes needed in clinics, to wider suggestions about adaptations required to the traditional lifestyle, given the breakdown of the extended family in the urban environment, and included plans to pressurise the government and the media to highlight issues felt to be contributing to depression in the national context. These recommendations have been published for local use (University of Zimbabwe, 1992).

Implementation

One recommendation was that locally relevant training materials be produced for the detection and management of depression, both within clinics and for the use of people working in organisations such as church groups and women's clubs. The Multiple Symptoms Card has been developed which leads primary health care workers through an algorithm to diagnose probable depression, followed by a seven-step management plan (Fig. 1a,b) (Broadhead & Abas, 1994*b*).

Guidelines on 'listening and talking', on 'asking questions', and on the involvement of culturally appropriate family members in problem solving have been combined with modern knowledge on the use of antidepressants and the assessment of suicidal risk. A pamphlet for the public has also been produced, giving information about depression and suggesting simple approaches to treatment, stressing, in line with traditional healers' views, that 'thinking too much' is different from 'madness', the latter being culturally viewed as caused by witchcraft or spirit possession (Fig. 2).

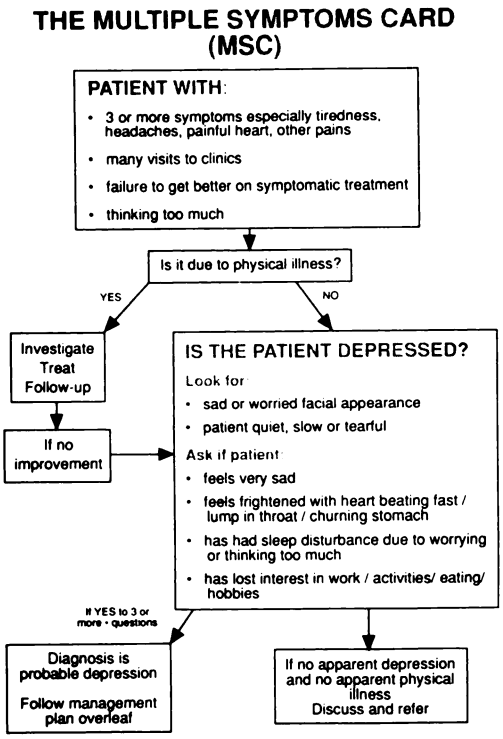

Fig. 1(a) The Multiple Symptoms Card: algorithm for diagnosis of probable depression.

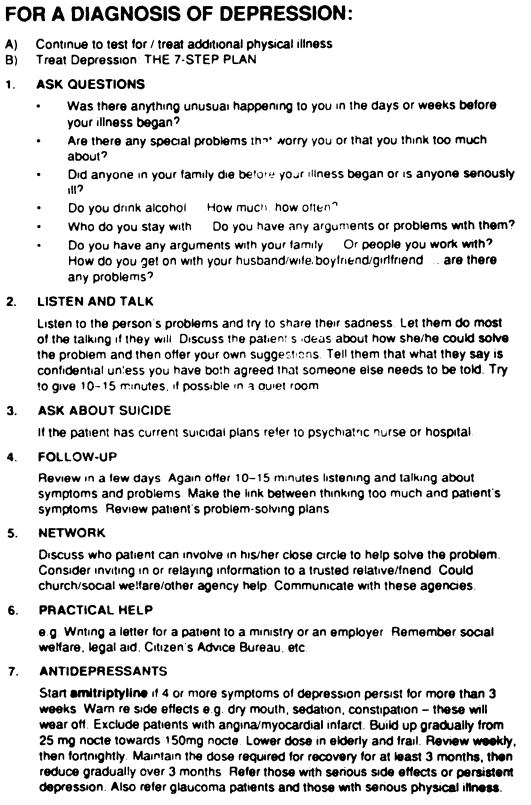

Fig. 1(b) The Multiple Symptoms Card: the seven-step management plan. Reproduced from Broadhead & Abas (1994*b*) with the permission of *Tropical Doctor*.

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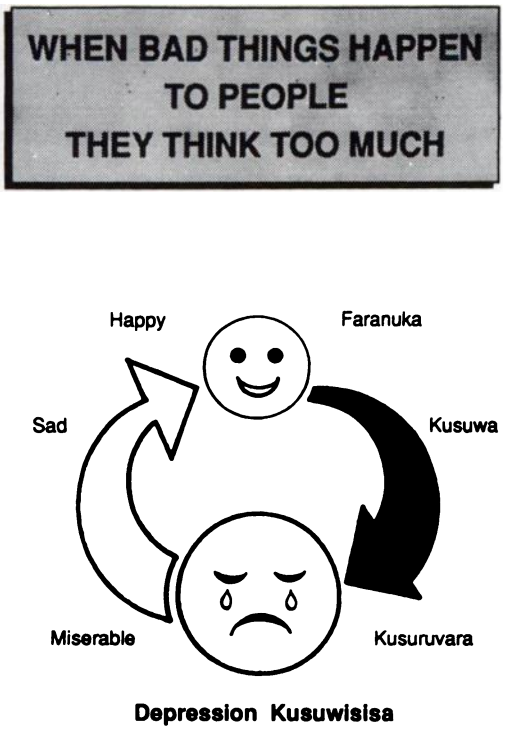

Fig. 2 Title page of pamphlet. Dispelling fears of depression.

Progress

Since the workshop, the senior community psychiatric nurse for Harare and a Zimbabwean member of the university research team have gained sponsorship to train primary care nurses from 30 urban polyclinics in the use of the Multiple Symptoms Card. Funds are now needed to expand and to evaluate the programme. Of particular interest, the training materials have been brought to life by a song and drama group who, with health representatives, are touring the townships of Harare creating interest and discussion among the public. The research model was presented at the 10th meeting of Commonwealth Ministers of Health, and the World Health Organization is considering composing a manual which could be used to launch similar projects in other developing countries.

Conclusions

Of note in the 300-page World Bank report, no comments directly address ways of confronting psychiatric disorders, although it is stressed that key factors in combating disease in general will be schooling, particularly of girls, income expansion, particularly of the poor, and the growth towards flexible primary health systems and away from tertiary specialisation.

Considering the complexity of potential causes and treatments for depression, psychiatrists might argue with the notion that a 'moderately cost-effective' intervention is available in any country. However, given that around 15% of primary care attenders across the world have a psychiatric disorder (Harding *et al*, 1980), and that those with depression will often present repeatedly, nurses are already spending time and resources on such patients. Surely it is sensible that time and those resources are spent most effectively, for example in carrying out basic counselling rather than in prescribing painkillers or in carrying out needless investigations. What is clear from the Zimbabwean example is that, despite severely limited resources, commonsense, low-cost programmes can be initiated and are seen by local people as worthwhile. The model used would be applicable in many settings and could be adapted by other countries.

Research

Research in developing regions should follow the principles of *The Uses of Health Systems Research* (Taylor, 1984). These are that it should have a focus on solving practical and relevant problems, that the priorities should be determined by local health workers rather than by outside academics, that as much as possible of the research should be carried out by those already working at ground level, that results should lead to implementable recommendations, and that the work not be considered complete until those are underway. Research of this type will bring about useful and sustainable change as well as fulfilling academic needs.

Staffing

A problem faced by many regions is their low number of psychiatrically trained staff. While visiting specialists might play a temporary role, active recruitment of local doctors to train in psychiatry is

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clearly a priority. Zimbabwe, for example, has fewer than 10 psychiatrists for 10 million people. As well as psychiatric input during every year of their medical student teaching, since 1990 around a third of housemen have had to rotate through the speciality, a policy which has already resulted in applications to stay on for postgraduate qualifications. In many countries a limited number of psychiatric nurses are available and are delivering the bulk of modern mental health care. Others might follow the lead of policy makers from Harare who encouraged their most senior and able community psychiatric nurse to take part in the project on depression with the result that she is now equipped to 'train trainers', so ensuring that knowledge will diffuse out to a wider network.

Developing projects for depression

In implementing programmes for depression, the most important aspect will be the interest and commitment generated by community participation. Clearly there are considerable resources already available for the management of depression, possibly more so in developing countries than in Western settings, but which need to be coordinated. The process highlighted from Zimbabwe involved traditional healers and community leaders from the start, initially in shaping the project and then in helping make sense of the results. Without their involvement it would have been impossible to formulate a comprehensive strategy which created confidence in health workers and which was also best placed to emphasise national problems such as lack of education and womens' rights.

While flow-charts and guidelines from international agencies have their use, we would argue that their role is limited. It now seems timely to facilitate the growth of more regional projects for depression which involve existing personnel and which promote the rich variety of locally available approaches towards prevention and management.

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