Swaziland

General Information

Swaziland is a country with an approximate area of 17 thousand sq. km. (UNO, 2001). Its population is 1.083 million, and the sex ratio (men per hundred women) is 92 (UNO, 2004). The proportion of population under the age of 15 years is 43% (UNO, 2004), and the proportion of population above the age of 60 years is 5% (WHO, 2004). The literacy rate is 82% for men and 80% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 3.3%. The per capita total expenditure on health is 167 international $, and the per capita government expenditure on health is 115 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Swazi. The largest ethnic group(s) is (are) African. The largest religious group(s) is (are) Christian (more than half), and the other religious group(s) are (is) indigenous groups.

The life expectancy at birth is 36.9 years for males and 40.4 years for females (WHO, 2004). The healthy life expectancy at birth is 33 years for males and 35 years for females (WHO, 2004).

Epidemiology

Guinness (1992) conducted a survey of 2040 senior secondary school students in different types of school (rural, urban and elite) with open-ended questions and SRQ-24. Symptom prevalence was generally higher among the rural and semi-urban schools in comparison to the schools in the city. The SRQ-24 items screening for psychosis were associated with a range of spontaneous symptoms representing anxiety. Neurotic symptoms were expressed in the form of 'spiritual' problems and it was concluded that under stress these could cause transient reactive psychosis. In a study on school-going adolescents and young adults from a combined sample from clinics and the community, Guinness (1992) found that the common presentations of psychopathology were somatized anxiety (brain fag), depressive neurosis characterized by hypochondriasis, cognitive complaints, dissociative states, culturally determined paranoid ideation and brief reactive psychosis. There was a temporal relationship between transient psychosis and the school calendar. Anxiety or depression often predated the florid psychotic reaction which served as a form of help-seeking behaviour or defence in intolerable stress. In a hospital based study, Guiness (1992) compared patients with brief reactive psychosis with patients of schizophreniform disorder, schizophrenia and manic-depressive psychosis. Brief reactive psychosis was found to be a composite syndrome with 50% showing a preceding history of depression. Of those with prodromal anxiety, most were precipitated by a major life event and a few showed a recurrent pattern. Schizophrenia occurred months or years later in 10-20%. The schizophreniform group comprised of symptoms intermediate between the transient and major psychoses. The pattern of precipitants and the over-representation of education and paid employment in the acute syndromes, compared with the major psychoses, in a society which was largely first-generation educated, suggested a link with rapid social change. Stephens et al (1999) compared eating behaviours of university students from Australia and Swaziland using EAT 26. The results did not support the hypothesis that more Australian students than Swazi students would display eating disorder symptoms.

Mental Health Resources

Mental Health Policy

A mental health policy is absent.

A draft policy is available.

Substance Abuse Policy

A substance abuse policy is absent.

National Mental Health Programme

A national mental health programme is present. Details about the year of formulation of the programme are not available.

The current focus of the mental health programme is on the development of standardized guidelines for diagnosis and management of common mental health disorders.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 2002.

Mental Health Legislation

There is a Mental Health Act.

The latest legislation was enacted in 1978.

Mental Health Financing

There are budget allocations for mental health.

The country spends 0.3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are out of pocket expenditure by the patient or family, private insurances, social insurance and tax based.

Mental health services are free.

The country does not have disability benefits for persons with mental disorders.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. The great majority of severe mental disorders are transferred to the National Psychiatric Centre.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Lack of transport and shortage of staff have adversely affected the functionality of community outreach services for patients with mental disorders.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	2
Psychiatric beds in mental hospitals per 10 000 population	2
Psychiatric beds in general hospitals per 10 000 population	0
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.1
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	10
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0.1
Number of social workers per 100 000 population	0.1

Mental health services are mainly managed by nurses. There is only one hospital, the National Psychiatric Centre, fully dedicated to mental health. In addition, two general hospitals have functional psychiatric units and capacity to admit severe mental health patients. Beds have been earmarked for women patients.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in promotion, prevention and rehabilitation.

Information Gathering System

There is no mental health reporting system in the country. Mental health reporting is not well established but is presently being addressed.

The country has no data collection system or epidemiological study on mental health.

Programmes for Special Population

A special programme addresses the needs of epileptic patients.

Counselling services and offered, but they are hampered by the shortage of trained staff. Mental health talks are delivered at health facilities, schools and tinkhundla centres.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden.

These drugs are not routinely available at the primary health care level.

Additional Sources of Information

•Guinness, E. A. (1992a) Brief reactive psychosis and the major functional psychoses: descriptive case studies in Africa. British Journal of Psychiatry, Supplementum 16, 24-41.

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•Guinness, E. A. (1992c) Relationship between the neuroses and brief reactive psychosis: descriptive case studies in Africa. British Journal of Psychiatry, Supplementum 16, 12-23.

•Stephens, N. M., Schumaker, J. F., Sibiya, T. E. (1999) Eating disorders and dieting behavior among Australian and Swazi university students. Journal of Social Psychology, 139, 153-158.

•Ministry of Health and Welfare. Swaziland. National psychiatric centre. Http://www.gov.sz/home.asp?pid=212.