

## Republished Article

# First Tigani El Mahi Memorial Lecture\*

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### Source:

<sup>1</sup> El Safi A, Baasher T. Selected Essays - Tigani El Mahi. Khartoum University Press, Khartoum 1981:1-4.

<sup>2</sup> Biography of Doctor Eltigani Elmahi. Available at: <http://eltiganielmahi.com/en/>.

## INTRODUCTION

When Dr. A.C. Raman, the Secretary General of the Association of African Psychiatrists, invited me to deliver the first Tigani El Mahi Memorial Lecture I accepted this responsibility, despite its difficulties, for several reasons. Notably for the reason that the decision regarding this lecture, to which I subscribed, was taken in 1972, during the Third Pan African Psychiatric Congress in Khartoum, Tigani's home city, and primarily because I had been closely associated with Tigani as a student, colleague, co-worker and above all as an intimate friend for more than sixteen years. Hence, am highly appreciative and indeed greatly honored by this invitation.

My presentation will consist of two parts. The first is a statement of appreciation to memorialize Tigani and the second deals with the theme of African Psychiatry: Search for a Model.

### Tigani El Mahi

Tigani El Mahi, born and bred in Arica, was no different from the majority of the Sudanese community living along the White Nile at Kawa, where his family lived. His attitude of mind was generally influenced by the social code, the religious values, the rich history and the long strivings of the Sudanese people. His

tempo of life and behavioral impulse reflected the rapidly emerging African society, from that of foreign domination to independence and freedom, from the traditional to the modern, with the new hopes after the Second World War and the universal social consciousness which was increasingly felt, Tigani took up psychiatry as a specialty. When he completed his post-graduate studies in London in 1949, he was not only the first qualified Sudanese physician to do so but also the first African. Later on, when he became known for his original thinking and addressed as "the father of psychiatry in Africa" he often reacted with his well-known sense of humor by pointing out that psychiatry in Africa had many mothers and he did not think that he was one of them.

His studies of behavioral sciences and the treatment of the mentally-ill was only one aspect of his extensive interests which covered a wide range, including hieroglyphics and other African languages. On introducing him in 1959, at a meeting on "Africa: Social change and Mental Health" organized by the World Federation for Mental Health at the United Nations, New York, Dr Brock Chisholm remarked that "Dr Tigani is a psychiatrist of note. I have seen him in a great variety of situations among varieties of people qualified in many aspects of technology. In

\*Delivered at the 4th Pan African Psychiatric Congress at Abidjan, Ivory Coast, June 1975. Appeared in *Af. J. Psychiat.* (1976) 3, 321-331

**How to cite:** Baasher TA. Republished: First Tigani El Mahi Memorial Lecture Sudan J Paediatr 2013; 79-89.

every case Dr. Tigani El Mahi has been outstanding, in a meeting discussing Africa or indeed other countries as well. His experience is wide and how he has been able to make it so intensive at the same time that it is so extensive, I have not yet been able to understand. Probably his searching mind, exceptional drive, boundless interest in human behavior and his courage and sincerity made that unique personality of Tigani. To him the image of the physician was not unlike that depicted by Nezami, the Persian author in his book *Gehar Magala*, which he often quoted. Nezami stated that: "The physician should be of tender disposition, of wise and gentle nature and more especially capable of deriving the unknown from the known. And no physician would be of tender disposition if he failed to recognize the nobility neither of man; nor of a wise and gentle nature unless he were acquainted with logic, nor an acute observer unless he is supported by God's guidance". From this he could infer that the student should be brought up to become a physician much endowed with the sense of human relationship so important in mental health work.

To appreciate Tigani's approach to mental health problems one has to take one's memory back to the late forties, when psychiatry in Africa was still in its very early infancy. Among the various issues which concerned him at that time were the concept of mental health, the socio-cultural aspects of psychiatric disorders and the development of a viable and dynamic system of psychiatric services. In his quest for the definition of the scope of mental health and the elucidation of the nature of its concepts, he emphasized consistently the notions of time and space, because he believed that the phenomena of mental health were evidently changing in the past, were still changing and would continue to change in the future. He felt that "it is even still less realized that mental health is not entirely a medical concept; not a social doctrine; not a religious idea; not an economic concept; not ever the work of fate or destiny but is a harmoniously

integrated complex of all these in varying proportions subject to the influence of time and space". The point he endeavored to bring home into the psychiatric field was to conceive mental health in its proper historical perspective, in its wider socio cultural dimensions and outside the traditional medical system. This was vividly expressed in his inaugural address at the First Pan African Psychiatric Congress, when he said:

"In African psychiatry one can follow the early inception, metamorphosis ripening and diffusion of the world psychiatry of today. Therefore, in the meeting. . .our deliberations under the shadow of this great continent was lead us to new perspectives of understanding where the historical, sociological economic and cultural factors merge and interact and finally emerge part and parcel of the mental health concept. Here in Africa the illustration that health is the community will be brought home to us more . . .clearly than anywhere else, for the hand of evolution here is still actively experimenting."

These concepts continued with more vigour and were applied in wider dimensions when he left clinical practice and later joined the WHO Office in Alexandria, as the Regional Adviser on Mental Health for the Eastern Mediterranean Region, or as a Professor and Head of the Department of Psychiatry, University of Khartoum or indeed in his temporary office as a member of the Supreme Council, the Democratic Republic of the Sudan.

In his action and thinking, human values, the dignity of man, the examples and personality traits of great men of history, whom he studied in depth, featured eminently. Remarkably, they continued to be a lively source of inspiration and useful reference of wisdom and experience.

He was a profound scholar of the history of medicine and keenly shared Sir Winston Churchill's view that history may" endow us with new concepts with the help of which we may be able to elucidate phenomena

which might otherwise appear chaotic”, and” so will philosophy, literature and other social sciences without exception”.

Being conscious of this influence, and referring to the Eastern Mediterranean Region with its ancient cultures and “countries of universal religions, of prophets and miracle mongers “, he affirmed that” inspiration comes mainly from men and not from ideas.... and that the physician must have a value system ; he must support the values of his community and of his day ; he should uphold what is right and true in his belief and finally, he should not act as a rebel for the sake of acting as such”.

He often remarked that it was not our task to teach morality and conduct, “but to conceive, and to pursue and implement our duty within the moral and ethical frame work of our communities”.

To this end he worked hard, nationally, regionally and internationally. The impact he made can be generally felt in his efforts to raise psychiatry, as an academic discipline and in practice, to its rightful place, to give it the often neglected social context and imbue it with meaningful cultural heritage. He certainly succeeded in making several countries more sensitive to the growing needs of mental health. His classical memos on such complex subjects as drugs will remain the true testimony of his encyclopedic knowledge and insightful synthesis of history, anthropology and psychological medicine. Dr. V. Neale, once the Professor of Paediatrics, Faculty of Medicine, Khartoum, addressed Tigani after a series of discussions by saying; “You could not have acquired all this in your lifetime....you must have lived twice to do so”. And he was right.

#### **AFRICAN PSYCIDATRY: SEARCH FOR A MODEL**

Psychiatry in Africa, in thought and practice, like medicine in general, “has a long past but a rather

short history.”Indeed the art of mental health has been deeply rooted hi the African culture as shown in recorded history. Temple sleep, shrine therapy, the use of narcotic drugs and even neurosurgery have been reported. The therapeutic function of shrines, as seen today in many parts of Africa is but one example of a variety of the legacy of the rich heritage.

As a matter of fact all over the length and breadth of Africa today traditional healing practices exist side by side along with modern psychiatric approaches. However, among the central issues which one has often to contend with are the centuries-old beliefs, the social values, the community attitudes and a host of psychiatric manifestations which are the product of ecological and cultural interactions; quite different from conditions prevailing in technically advanced countries. Not surprisingly the pioneer African psychiatrists all of them being trained abroad encountered practical difficulties of case identification, of clinical diagnosis and choice-of therapeutic modalities. Naturally the model of the treatment process, as applied elsewhere has to be modified to suit the socio-economic as well as the cultural setting. One would therefore tend to agree with Tigani regarding the doctrines and application of psychoanalytic practice in Africa, when he stated in 1953 that the “gulf between the therapist and patient is so wide and their concepts as to what constitute illness and recovery so different, that rapport necessary for the opening phase of treatment never occurs.” It is to be remembered here that the classic psychoanalytic model has undergone continuous changes since the late thirties even before the introduction of modern psychiatry in the great majority of African countries. On the whole from the growing psychological, anthropological and psychiatric literature as well as from the point of view of the peculiarities of the clinical and therapeutic approaches, a beginning for an African psychiatry, though not belonging to one school, seems to be in the making. There is no

doubt that the activities of the African Psychiatric Association, its newly established journal and its elder sister Psychopathologie Africaine will continue to enhance such a trend. Over the last two decades various attempts have been made in several African countries to develop a psychiatric model for either assessing the magnitude of the mental problems or establishing a psychiatric care system capable of evolving effective therapeutic and rehabilitative programmes.

The stages through which African psychiatry has passed in its recent history seem interesting and instructive. These stages can be delineated historically into three evolutionary periods. The first was that of the clarification of the nature and extent of psychiatric disorders. The second was that of the exploration of the general needs and potentialities of the community resources. The third was the initiation of treatment models to meet such needs and attempts for utilization of available resources.

### **The Stage of Clarification**

Until the beginning of the last quarter of the century, the available psychiatric information on the nature of psychiatric disorders, their incidence and prevalence in Africa was generally misleading and often confusing. Most of the literature on traditional healing and magico-social practices was written by anthropologists and missionaries. The little known on psychiatric disorders was based on findings in mental hospitals and on prison inmates. It is not surprising then, that the disparity of the extent of psychiatric disorders between what is generally known in Western Europe and what was reported from Africa was amazingly great. Carothers for example, based on hospital statistics, estimated the incidence of psychiatric disorders in the former as much as thirteen times greater than what he observed in East Africa. These findings as well as others perpetuated the fallacy of the comparatively low incidence of

mental illness in developing countries. The model of isolated hospital statistical studies was soon found to be of limited value, and field surveys such as those carried out in Ghana by Fields proved more searching and more informative. Significantly, it revealed the greater extent of some of psychiatric disorders, such as depression, which were hitherto thought to be rare in African communities. Though it is not intended to discuss in details here the outcome of the interesting epidemiological studies which followed, it may be relevant to point out that some of these studies are worthy of note not only because of their findings but also for the new possibilities which they showed and the types of models which they demonstrated. The rural-urban studies in Ethiopia, the inter-disciplinary or team approach as presented by the Cornell-Aro survey, the Kalakla and Hag Yousif studies of Sudanese children and psychiatric disorders among student groups in Kampala, Khartoum and Nigeria are but a few examples. In these studies and others came to the important conclusions that the frequency of psychiatric disorders in Africa is not different from what has been observed elsewhere, and that socio-cultural influences may color some of the psychiatric disturbances with certain features peculiar to the community or communities under study. Furthermore, though differences in frequencies may be attributed to adverse physical factors such as infection, malnutrition and toxic agencies, which are still in the forefront of public health problems in Africa, knowledge of the socio cultural factors is very important in the management and treatment of patients.

### **Exploration of Needs and Resources**

Apart from indicating the extent of the psychiatric disorders these various studies have pointed to the growing needs, which have been generally felt for mental health services. In contrast to these overwhelming needs were the meagre resources in all the countries concerned. In 1960, for example,

there were only two medically qualified African psychiatrists in the Sudan and a similar number in Nigeria. The existing psychiatric model at that time was the psychiatric hospital or the psychiatric prison, both alien to the African culture and both adversely reported upon. Dr. Lambo's experience, which is not different from that of contemporary African psychiatrists, is graphically illustrative and particularly worthy of notice. For he "spent about 2 to 3 years...more or less, trying to find out what were the actual needs in Nigeria and what in practice would be acceptable to the population of Nigeria." I did the same in the Sudan.

Together with the assessment of needs the exploration of community potentialities and resources continued. This seems a logical thing to do. For the African societies through all their histories have continued to develop their traditional ways and means and every country and indeed every generation had its techniques for dealing with emotional and mental disturbances. The outcome of this is the variety of suggestive techniques, group therapy, healing cults, all sorts of divination processes and forms of "social analysis" dream interpretations, drug medication, various protective designs and prophylactic procedures and so forth. An interesting and unique example, is the traditional therapeutic villages found in Northern Sudan, some of which date back more than 300 years and are still actively functioning.

The pioneer African psychiatrists did not evaluate any psychiatric care services, for there were none. Alternatively, there were five possibilities from which to choose, namely the style of services with which he became familiarized abroad and which cannot be transplanted in toto; the existing hospital-prison model; the traditional system; a combination of II; or taking up the challenging approach of "experimentation and innovation". Fortunately, pioneer psychiatrists like Tigani, Lambo, Collomb

and others opted for the latter.

### **African Psychiatric models**

With the promising international movement of mental health in the early fifties, the advent of the potent psychotropic drugs in the mid-fifties, the rich potentialities of the African communities and the accelerated social change practically all over the continent, the time seemed ripe for new experimentation and constructive innovation. Certainly a variety of interesting psychiatric models have been developed and within the scope of this paper and time limit reference will be made, in brief, to some of them.

Two important areas were the focus of attention; (a) the development of psychiatric care services extra institutionally into community care within the socio-economic context and (b) the incorporation of psychiatric care into the total health system.

### **Extra-institutional care**

Though the central philosophy of extra-institutional care aims at enabling the patient who is under treatment to live as near a normal life as possible, the pivotal point of such a programme rested on the support given by the family, the readiness of the community to retain the mentally-ill persons and in the socio-cultural setting which will facilitate such a therapeutic approach.

To relieve the pressure on the psychiatric hospital and in-patient units in Tanzania, Dr. Swift developed the village for convalescent patients. Effective utilization was made of the ujama'a (cooperative) socio-political system and growing drive for self reliance.

In West Africa, two extra-institutional models seem of interest, namely the Nigerian village system and the Liberian Mental Health Centre and its extended services.

Other modified versions have been developed and for the sake of brevity it is sufficient to refer to

these two. Furthermore, it is not intended to go into any particular details of these two projects for they have been described else-where. However, it is to be remembered here that, as pointed out by Lambo “the original experiment took the form of a “village system” which permitted full treatment of the mentally-ill by utilization of inherent dynamic resources of the social environment as the principal therapeutic techniques”. The Liberian model which was originally evolved round the Catherine Mills Treatment Centre, was conceived as having what was referred to as guest villages for the provision of early treatment and the “creation of farms” as part of the restorative programme. Other services included a psychiatric in-patient unit and a clinic in the general hospitals.

The Sudanese experience is interesting in the sense that the original treatment centre was established in one of the premises of a residential area in Khartoum North, and the role of the family was fully recognized by the establishment of a family house for keeping the patient in close contact with his family, as well as with society, without undergoing the hazardous experience of intra-mural care. A pertinent question may be raised here, i.e. if the village system has been well traditionally established for centuries in the Sudan and is still generally popular, why has it not been further developed as an integral part of psychiatric services? The reasons for this seem to be historical, social and geographic. Historical, because the traditional village system has its roots in rural communities, while modern psychiatric services have been developed in urban centres. Social, for the village system fitted rather well with an agrarian and nomadic population. Geographic, for the traditional and modern institutions were at such a distance apart, that it was not feasible to establish an effective relationship and efficient cooperation. However, the channel of communication between the two systems continued to be usefully active. Some of the traditional healers having been oriented towards modern psychiatric thinking and

practices, proved helpful in early referral of patient, in providing support and guidance to patients where no other alternative medical care was available, in public education and in enhancement of community resources.

I find the Senegalese experience based on the effective collaboration between the Western-trained psychiatrist and the traditional healer most interesting. The model as depicted in the film entitled *Ndoep* shows how far this approach for involving non-professional, non-medical, community workers in mental health work can be usefully developed.

Another feature of African field psychiatry is the development of the mobile “psychiatric team”. More colorful names such as “bush psychiatry” and “psychiatric safari” have been given to this type of activity. Experience shows that such teams, which may or may not be headed by a professional mental health worker, can be extremely useful in extending psychiatric services into remote and rural areas. It has been found very useful in the follow-up of patients in to their home, in the small district towns and in the villages. An important aspect of this approach is the involvement of the front line general health workers in psychiatric work, and their stimulation towards giving attention to the psychiatrically-ill patient. Furthermore the mobile team can be actively utilized in training programmes for the primary health worker, in public enlightenment and in community research. This will lead us to the next issue, the incorporation of psychiatric care services into the general health system.

#### **Incorporation of psychiatric care services into the general health system**

The move for establishing psychiatric clinics and in-patient units in general hospitals, following its initial success in several African countries, are gaining more and more, both in momentum and ground. This proved so essential not only for overcoming the long-standing

isolation of psychological medicine and for identifying psychiatric disorders with other medical conditions but also for gaining the support and confidence of the community and for providing easily accessible facilities for treatment and for the training of medical students, as well as the general health workers. This pattern of psychiatric care services in some African countries such as the Sudan has superseded the one-time popular trend for the construction of psychiatric hospitals as the main centers for residential care. Its flexibility and economy as well as its organizational advantages have made possible its extension into the existing medical services. It is clear now that it constitutes an important pivotal point for meeting part of the coverage which, needless to say, is most essential in mental health programming.

An essential component of this pattern of approach is the training programme, basic and post-basic, for the various levels of general health workers. In the light of past experience and for strengthening the incorporation of psychiatric care services into the total health system in the Sudan, a countrywide programme, with WHO consultation and with the main emphasis on psychiatric training, is now under way.

Workers in other countries, such as Swift in Tanzania, Howarth in Zambia and Egdell in Uganda had also emphasized the important role of general health personnel in mental health work. Egdell in particular, recognizing the major role played by the medical assistant in "up-country medical services", considered him an important front line potential leader for providing psychiatric care, if he is properly trained for such a job.

Wintrob's three-level person model which was based on his experience in Liberia puts the top priority on personnel development, and training. In brief, the essence of this model focuses on the development of a network of non-medical local community mental health workers, a group of psychiatric nurse supervisors and regional psychiatrists. Clearly the

interesting feature of this model is the development of non-medical mental health workers from members of the local community.

The use of local community workers in general health, such as the local dresser or the village midwife is not new in some African countries. However, to engage them in psychiatric care, and organize their work within the hierarchy of a mental health system, is certainly innovative and promising. The possibilities and limitations of this model as well as others will be generally discussed later.

However, while discussing this issue it is important to mention that the provision of psychiatric care for special groups such as mentally-ill offenders is still at a rather rudimentary level and the pattern of services continues to be mainly of confinement to units or special wards in general prisons or mental hospitals. Exceptionally, there are special separate institutions as are found in the Sudan for providing deferential care, and yet such care constitutes a complex area for its legal, social and medical implications. A similar situation obtains in the field of the management of drug-dependent persons and alcoholism. Though alcoholism has not often been reported in the top list of mental health problems in Africa, there is an increasing concern in several countries, as its complex problems have been growingly felt. Wood (1968) for example, reported that alcoholism constituted as much as thirteen per cent of all admissions to Butabika Mental Hospital, Kampala. The epidemiological studies of this socio-medical problem are still limited. Nonetheless studies such as the one going on at the present moment in Khartoum have already yielded interesting results. At least they have shown that the magnitude of the problem was greater than has hitherto been known.

Another area which has been the focus of recent study is opium dependence and the clinic which was developed in Cairo in 1971, and run on a voluntary and ambulatory basis, showed encouraging results.

Considerable attention is given to the social and cultural aspects of this intriguing problem and to the role of the family. Psychotropic drugs together with insulin are used in selected and relatively few patients. Other countries in WHO Eastern Mediterranean Region, which have been using methadone-withdrawal detoxification therapy for opium dependent persons with less emphasis on the social and cultural implications of treatment, seem to have a relatively high percentage of relapses and hence its efficacy has been seriously criticized and the search for better alternative techniques has been keenly considered.

Besides mentally abnormal offenders and drug- and alcohol-dependent persons, differential care for mentally retarded and delinquent children deserves to be mentioned. Here again the development of such services has been rather slow and the types of facilities few, though they maybe such as Children's Guidance Clinics and Remand Houses, seems to imitate the existing pattern of technically advanced countries. The Second Pan African Psychiatric Workshop dealt in some detail with this topic under its central theme; "Mental Health of Children in Developing Countries" and I do not intend to elaborate it further. However, I find Dr Asuni's concluding remarks on the Facilities for Dealing with Children's Psychiatric Problems timely and necessary. While the duly pointed out the general lack of facilities and trained personnel he rightly warned against the danger "of copying the system of Remand Homes and Approved Schools practiced in Western countries". I concur with him that "we need to carry out experiments... to find out the best way to treat those delinquent children needing residential treatment".

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## DISCUSSION

Evaluative studies of the existing pattern of psychiatric services in Africa have been rarely undertaken. In the

absence of accurate statistical data it would be rather difficult to reach any valid conclusions regarding efficacy of the therapeutic modalities and efficiency of the various psychiatric systems.

It is now clear that there is a range of pattern of psychiatric care which has been developed in several countries of Africa, and their comparative studies would have been useful for better planning and future programming. However, until reliable information becomes available, our assessment will continue to be impressionistic and anecdotal.

The models of community care which have been developed in Africa have drawn considerable attention. The reasons for this may be:

- (a) because they followed modern trends, held many possibilities and fitted into the socio-cultural setting of some of the African society;
- (b) because they came at a time when community care services in Euro American societies have been criticized and carefully scrutinized;
- (c) because of the difficulties of establishing effective rehabilitative models, especially for non-responding chronic psychotics.

It is assumed that one of the advantages of workers in developing countries is that they learn from the experiences and mistakes of other technically advanced nations. It is therefore important to be reminded of the change of attitude towards community care for example in UK from that of the early sixties with the rising hopes of reducing the number of psychiatric beds and even of doing away with mental hospitals to that of the early seventies and their strong criticism. The important argument which was put forward was that some of the patients who were previously protected by the mental hospitals, were denied this protection due to the inadequacy of the community services; the outcome of this was that they tend to swell the number of vagrants; unemployed and criminals."

Such criticism is understandable, and should be



encouraged for the very reason that it will contribute to the improvement of the quality of community care and avoid unrealistic claims in dealing with such intriguing problems as the care of chronically-ill psychiatric patients.

In the African scene, however, after nine years of experience, Dr Lambo (1965) gave an excellent review of the Nigerian village system. The social, medical and economic advantages which he lucidly cited seem plausible and generally encouraging. On the other hand, the limitations of this scheme, such as its applicability to non-industrial agrarian communities as pointed out, raise the question of other alternatives for community-care services in the more complex urban centers, where models of excellence are still lacking.

Furthermore, the development of entirely new villages as seen in the Tanzanian model has been criticized for its lack of traditional basis and social cohesion. Others viewed the village set-up as a mere chronic hospital annexes. Positively, whatever shapes the criticism or short-comings of the village system may take, it still remains as one of the best available models which are operationally feasible within the rural African setting. The centuries-old traditional healing villages in the Sudan provide a vivid example of the durability of such a model, which is apt to change with time to accommodate the growing needs of the community.

Again the Liberian model which combines the local community resources with the central psychiatric facilities opens up the way for greater possibilities for manpower development and wider coverage. However, one of the bi obstacles which face such a system is the organizational framework. In many developing countries, it has been found that psychiatric services, based as they were on the traditional clinic or hospital model, generally suffered from the lack of efficient organizational framework, which can effectively mobilize the potentialities of the community resources and make proper use of

other available social services.

A pertinent question which may be raised here is why do we go out of the total health system and engage local community workers in mental health, while we have readily available resources in the general health workers? There is no doubt that the dresser, the village midwife, the medical assistant and other health workers, who constitute the first line of contact of health care, as already pointed out, can extend mental health work into wider areas if adequately trained. The latter approach has been carried out in several countries and proved effective. The use of local non-medical community workers has yet to be developed. Obviously there seems to be no reason why the two cannot be developed. All depends on the efficacy of the system to be developed, its organizational framework and the local conditions where it will be applied.

If the discussion is now shifted to the intramural institution, it is instructive to note that in-patient psychiatric units in general hospitals have filled in an essential gap in the network of facilities. However all the existing patterns as seen in the different general hospitals or in teaching units such as those of Dar-es-Salaam, Kampala, Ibadan, Khartoum or Cairo are for short-stay hospitalization and are not designed to be comprehensive. The need for long-stay hospitalization, especially for the care of schizophrenic reactions which form the great majority of chronic patients, has been increasingly felt in urban centres. Although the psychotropic depot injections has reduced the duration of management and facilitated the extra-mural care of these patients, the rehabilitation programmes in many countries are still defective and far from being really effective. Hence the number of chronic psychotics tends to grow and the search for better restorative programmes should continue.

From all the available models, it is clear that there is no one golden rule or one sacred line to be followed, but that all the potentialities of the communities should

be explored along the universally accepted principles. So far African psychiatry has made a beginning in this direction, and the possibilities are many for further development, realistic proliferations and practical diversifications.

In concluding may I repeat how appreciative I am of being given this opportunity to deliver this Memorial Lecture.

Tigani, once on being invited to introduce the topic of

mental health in Africa quoted William Shakespeare that part from King Henry the Fourth, which reads: "I speak of Africa and the golden joys".

But he would rather speak of Africa and leave the golden joys to the future. I am sure, if he was in this gathering he would have stated it differently; for he would have seen at least part of the "African joys" to which he contributed so generously and wholeheartedly.

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