

Retail Price' (MRP) on medicine packaging and medicines are generally sold at this printed price. The NPPA does not allow the prices of non-scheduled medicines to rise more than 10% in any one year. Theoretically, market forces could check the prices of non-scheduled medicines – India's 20000 generic manufacturers should generate sufficient competition to keep prices affordable.

Recommendations

The poor availability of medicines in the public sector could be ameliorated by government pooled procurement of a sufficient regular supply of all essential medicines and increases in the drug budget. Besides these resource-intensive measures, policy-makers could undertake the following steps:

- develop and implement standard treatment guidelines for psychiatric diseases at primary and specialist facilities
- educate doctors and pharmacists to recommend cost-effective generics
- encourage consumer awareness of the affordable generic equivalents, through media campaigns
- legally permit chemists (retail pharmacists) to substitute cheaper versions.

Both federal and local governments have piloted generic drug stores that sell affordable medications (Kotwani, 2010); such stores could also stock reasonably priced psychiatric medicines.

References

- Creese, A., Kotwani, A., Kutzin, J., et al (2004) Evaluating pharmaceuticals for health policy in low and middle income country settings. In *Evaluating Pharmaceuticals for Health Policy and Reimbursement* (eds N. Freemantle & S. Hill), pp. 227–243. Blackwell Publishing, BMJ Books and WHO.
- Health Action International (2011) Medicines prices, availability, affordability, and price components in NCT, Delhi – using WHO/HAI methodology. Available at <http://www.haiweb.org/MedPriceDatabase/> (accessed 24 March 2012).
- Kotwani, A. (2010) Will generic drug stores improve access to essential medicines for the poor in India? *Journal of Public Health Policy*, 31, 178–184.
- Kotwani, A., Ewen, M., Dey, D., et al (2007) Medicine prices and availability at six sites in India: using the WHO–HAI methodology. *Indian Journal of Medical Research*, 125, 645–654.
- Kotwani, A., Gurbani, N., Sharma, S., et al (2009) Insights for policymakers from a medicine price survey in Rajasthan. *Indian Journal of Medical Research*, 129, 451–454.
- Math, S. B. & Srinivasaraju, R. (2010) Indian psychiatric epidemiological studies: learning from the past. *Indian Journal of Psychiatry*, 52, S95–S103.
- Patel, V. (2008) Mental health in the developing world: time for innovative thinking. Science and Development Network, 23 July. Available at <http://www.scidev.net/en> (accessed 4 March 2012).
- Singal, G., Nanda, A. & Kotwani, A. (2011) A comparative evaluation of price and quality of some branded versus branded-generic medicines of the same manufacturer in India. *Indian Journal of Pharmacology*, 43, 131–136.



Does mental health matter? Commentary on the provision of mental health services in Mozambique

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Despite attempts made in recent years to address the diagnosis and treatment of mental illness in Mozambique, service provision remains deficient. The present paper focuses on the attitudes to mental illness and its diagnosis and treatment in Mozambique. This paper is based on both a thorough literature search and on the results of qualitative interviews carried out with six individuals of Mozambican origin now living in the UK.

Mozambique is a country with a population of about 21 million, characterised by low income, high rates of infectious disease (mainly malaria

and HIV/AIDS), poverty, starvation and low life expectancy. Public sector services are poorly resourced. The main languages are Portuguese (the official language), Emakua, Xichangana and Elomwé. The largest religious group is Roman Catholic, although there are also many Muslims and indigenous belief systems are widespread (World Health Organization, 2005).

Perception of mental health in Mozambique

Mental illness is often interpreted in Mozambique through a traditional ancient belief system. In particular, it may be seen as retribution by the spirits of the deceased for any wrong done to them

while alive. Hence, there is sometimes a belief that spirits can haunt individuals and families for generations and that the dead have the ability to communicate with the living (Dopamu, 1979). Families usually view mental disorders as being a result of witchcraft, that is, a spell cast by a jealous neighbour or a relative that can be reversed only by consulting a traditional healer or a religious master (Idowu, 1973). Additionally, it is felt that spirits may be dissatisfied if a ritual appears not to have been performed accurately and a subsequent cleansing ritual has then to take place. Only traditional healers have the power to perform these rituals, as it is believed that they can communicate with the dead and obtain atonements. Families sometimes have to sell their livestock to pay such healers or confer their animals as offerings to the ancestors. This results not only in poverty but also in additional mental stress for families.

Often, relatives may want to distance themselves from family members who have a mental illness because of a fear of the association with supernatural powers. This leaves the individual unsupported, even abandoned, without hope of any family help with their mental health problem. In line with this, the general public typically have little respect for anyone in mental distress. Furthermore, because of the extensive use of cannabis and alcohol, people are often left untreated, as uncharacteristic behaviour is usually attributed to cannabis and/or alcohol intoxication.

Epidemiological issues

Mozambique experienced a violent civil war from 1977 to 1992 in which the majority of the population were exposed to traumatic events, including witnessing the brutal mutilation and murder of family members and people's own experience of physical and sexual assault. The associated post-traumatic stress disorder (PTSD) and depression have only partially been addressed, because the resources the government has been able to direct to such problems have been limited.

In 2003, the Ministry of Health carried out a community survey in both urban and rural districts. The prevalence rates of psychoses, intellectual disability and epilepsy in urban areas were 1.5%, 1.1% and 1.3%, while the prevalence rates of these disorders in rural areas were 5.0%, 1.8% and 3.9%, respectively. Rural-urban differences were highly significant (Ministry of Health, 2002-03; World Health Organization, 2005).

Granja *et al* (2002) conducted a retrospective hospital-based study on deaths from injuries among pregnant/postpartum women ($n = 27$) and found that suicide was the cause in one-third of cases.

Mental health resources

The National Mental Health Programme was formulated in 1990 and a draft National Mental Health Strategic Plan has been approved.

There are three medical schools in Mozambique: two state schools, in Maputo and Nampula,

and one at a privately funded university in Beira. These are unable to meet the need for medical training, and there are very few trained specialist doctors and mental health nurses.

Overall, Mozambique has a basic mental health system organised into:

- services based within primary care facilities – for example, mental health nurses are located within health centres throughout Mozambique's 11 provinces
- hospital services, both in-patient and out-patient.

There is, though, only one psychiatric hospital in Mozambique, located in the capital city, Maputo. It mainly treats individuals with severe mental health problems.

In addition, there is traditional healing. Healers and Church clergy are the first port of call for some families seeking to address psychological problems; this then delays any possible assistance from trained mental health services. Most clergy and traditional healers are not trained to address mental illness, and so people may not receive the necessary psychiatric care.

According to the World Health Organization (2005), there is a paucity of mental health beds and professionals. The provision per 100 000 population is as follows:

- total psychiatric beds, 0.23
- number of psychiatrists, 0.04
- number of psychiatric nurses, 0.01
- number of psychologists, 0.05
- number of social workers, 0.01.

Each province has at least two mental health professionals. Since May 2004, three newly trained Mozambican psychiatrists have joined the workforce; the remaining seven are foreigners. Out-patient and in-patient care is primarily at the provincial hospital level; mental health admissions are also made in general medical wards (World Health Organization, 2005).

Non-governmental organisations (NGOs) are involved with mental health in the country; some focus on the rehabilitation of people who misuse drugs. The World Health Organization (2005) has undertaken a project in some districts to integrate mental health into general healthcare at the primary level. Emphasis is given to psychosocial support in collaboration with traditional healers.

Traditional healers usually use roots that can be smoked or boiled and drunk, or used in bath water. Some people report miraculous improvement in their mental health and for this reason some of these healers are now licensed to practise legally. There is also a general belief that, before Western influence took sway over medical care, people were treated and cured via this route. As a consequence, those who seek treatment via hospitals are viewed as disrespecting culture and ancestral spirits.

All interviewees agreed here that in Mozambique most people would resort to prayers,

traditional healers and family before approaching mental health services, due to the stigma associated with mental disorder. As a consequence, although Mozambique is overburdened by mental illness, the use of mental health services is minimal.

Among the young, unemployment has gradually increased due to the use of alcohol and drugs, mainly cannabis. Seeking treatment from mental health services is costly and the stigma attached to mental disorder may mean these young people are left untreated. Some families even put relatives on a train to 'get lost'.

Conclusion

In relation to HIV, the Mozambican government has set objectives to change the widespread negative perception of the disease. This approach should be extended to mental disorder.

It would be timely and appropriate to revisit and reformulate the interventions employed to combat mental disorder. This is of particular importance as, in a proportion of cases, psychosis is

the result of infectious disease such as malaria, fever and HIV, or of cannabis misuse. People with mental disorders should be protected from being exposed to degrading experiences, and family support should be viewed as an important component of mental health treatment.

References

- Dopamu, P. A. (1979) Yoruba magic and medicine and relevance for today. *Religious Journal of the Nigerian Association*, 4, 3–20.
- Granja, A. C., Zacarias, E. & Bergstrom, S. (2002) Violent deaths: the hidden face of maternal mortality. *BJOG: An International Journal of Obstetrics and Gynaecology*, 109, 5–8.
- Idowu, E. B. (1973) *African Traditional Religion: A Definition*. SCM Press.
- Ministry of Health (2002–03) *Community Mental Health Study – A Household Key Informant Survey in Rural and Urban Mozambique*. Mental Health Program, Department of Community Health.
- World Health Organization (2005) *Mental Health Atlas*. Available at http://www.who.int/mental_health/evidence/atlas/en (accessed 5 January 2012).



Mental health in the Republic of The Gambia

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The Republic of The Gambia, on the west coast of Africa, is a narrow enclave into Senegal (which surrounds the nation on three sides), with a coastline on the Atlantic Ocean, enclosing the mouth of the River Gambia. The smallest country on mainland Africa, The Gambia covers 11 295 km² and has a population of 1 705 000. There are five major ethnic groups: Mandinka, Fula, Wolof, Jola and Sarahuleh. Muslims represent 95% of the population. English is the official language but a miscellany of minor languages are also spoken (Serere, Aku, Mandjago, etc.). The Gambia has a history steeped in trade, with records of Arab traders dating back to the ninth century, its river serving as an artery into the continent, reaching as far as Mauritania. Indeed, as many as 3 million slaves were sold from the region during the trans-Atlantic slave trade. The Gambia gained independence from the UK in 1965 and joined the Commonwealth of Nations.

The Gambia is a long and narrow country, with borders following the course of the river. Commerce and government, including most of the main healthcare facilities, are based in the Western Region, near the coast. About 55% of the population live in the Greater Banjul and Western Region, and with the influence of poverty, and poor travel infrastructure, much of the population of the hinterland is isolated.

The Gambia has enjoyed relative political stability, unlike many of its neighbouring countries. Nonetheless, the country ranks 168 out of 187 nations according to the United Nations Development Index 2011, and about two-thirds of the population live below the international poverty line of \$1.25 per day (Int\$, 2009). The annual expenditure on health per capita is \$84. Life expectancy at birth is 58 for males and 61 for females. The mortality rate for children under 5 years of age is 103 per 1000 per annum. The