Readers' Forum

Mental health policy — the Kerala initiative

Sir – The global burden of disease from neuropsychiatric conditions is expected to rise considerably by the year 2020, with increased prevalence of depression in developing countries (*1*). Health care delivery systems in developing countries are often grossly inadequate for the provision of mental health care. Governments should be made aware that an evidence-based, proactive mental health policy is an urgent requirement, so that mental health care facilities can be suitably improved to meet the challenges they will have to face.

Kerala is a small southern Indian state with an estimated 30 million inhabitants, whose paradox of good health and low income has attracted global attention (*2*).

The Kerala branch of the Indian Psychiatric Society has been instrumental in drafting a mental health policy for the state: suggestions were sought from all practising psychiatrists and, through the media, from patients, their carers, and the general public. That providers and users of care shared common concerns was apparent from the strikingly similar suggestions made by all groups. These suggestions were all considered by a subcommittee, and a proposal was drafted which is now being deliberated by the government.

The most significant aspect of this collaborative effort was the participation of users of services in the process of developing a mental health policy. Indeed, user–provider collaboration may be considered the basic minimum requirement for establishing and maintaining user-friendly mental health services. We would like to know more about similar initiatives undertaken elsewhere, and we will be delighted to share our experience with other readers. ■

K.S. Shaji, Assistant Professor
K. Praveen Lal, Professor
N.R. Arun Kishore, Assistant Professor
Department of Psychiatry
Medical College, M.G. Kavu
Thrissur, 680 581 Kerala, India
e-mail: shajiks@vsul.com

E. Mohan Das, Head
Department of Psychiatry
Elite Mission Hospital
Thrissur, Kerala

References

1. **Murray CJL, Lopez AD.** Evidence-based health policy: lessons from the global burden of disease study. *Science*, 1996, **274**: 740–743.
2. **Thankappan KR, Valiathan MS.** Health at low cost — the Kerala model. *Lancet*, 1998, **351**: 1274–1275.

Role of clinical pharmacology in the medical curriculum

Sir – There is worldwide agreement that medical education has to evolve in order to respond to changing attitudes: it must reflect the shift from curative to preventive medicine and the need of health systems to match resources to care that is both affordable and acceptable.

Problem-based learning has replaced the classic medical curriculum of theoretical instruction followed by a period of clinical training. Now it has been suggested that the problem-based curriculum be replaced in turn by a community-based method, which concords better with a preventive approach to medicine and a higher level of care at less cost to the health care system. Changes will therefore be required in medical schools, emphasizing disciplines that will serve society's interests and expectations perhaps better than previously.

One option concerns the role of clinical pharmacology. This relatively recent discipline was developed because of the realization that the safe and effective use of the increasing number of drugs being used in clinical practice could be greatly improved by scientific study and teaching. It is interdisciplinary and aims to increase knowledge through research and to pass on such knowledge — clearly the functions of a medical school. Clinical pharmacology should therefore be inserted into the university structure. In 1970 a WHO study group, considering that special training and experience were necessary to conduct studies on the effects of new drugs in man, proposed that clinical pharmacology units could be started within existing clinical or pharmacology departments, and could perhaps develop into independent departments (*1*).

Future doctors will need to assume new roles and responsibilities. Medical schools must prepare them for the multidisciplinary and multiprofessional exercise that decision-making in health care has become. I believe, therefore, that clinical pharmacology should be inserted firmly into the new medical curriculum. Thus trained, physicians will be able to respond to the changing needs of society, as clinical pharmacology is one of the guarantees of a better, cheaper, and more affordable health system providing a high level of care. ■

G.A. Balint
Professor and Head
Laboratory of Clinical Pharmacology
Department of Psychiatry, New Clinics
Albert Szent-Györgyi Medical University,
Szeged, Hungary
Address for correspondence:
P.O. Box 427
6701 Szeged, Hungary
tel: (36 62)455 366
fax: (36 62)420 752
e-mail: balint@nepsy.szote.u-szeged.hu

Reference

1. *Clinical pharmacology. Scope, organization, training. Report of a WHO Study Group.* Geneva, World Health Organization, 1970 (WHO Technical Report Series, No. 446).

Gender, health, and human rights in Egypt

Sir – All forms of discrimination in the social setting affect health. The phenomenon of gender inequality is apparent in a preference for male babies, longer breastfeeding of male infants, more food of better quality for boys and men, and high maternal mortality. This letter considers human rights in Egypt as they affect health, in particular socioeconomic and cultural forms of discrimination, access to health care, and women's empowerment in view of societal restrictions and relations of power.

Despite men's cultural obligation to support widowed, divorced or single women in the extended family in Egypt, 22% of households are headed by women. Adult literacy has improved slightly over the last decade, but the literacy rate for women (37%) is not much more than half that of men, which has implications for women's and children's health. Women in towns are more likely to be literate than those in rural areas.

© World Health Organization 1999

In Egypt there are cultural barriers to the use of health services by women. A national survey revealed that 27% of women only visited a health service or a doctor if accompanied by another adult, and that others would not use the services if there was no female physician (*1*). Despite support from the Social Fund for the establishment of a clinic run by female physicians in deprived rural areas, a study showed that women doctors found the cultural environment too restricting and would only participate if their husbands came from the same region.

In Egypt the mean age of women at marriage is 21.9 years; 12% still marry below the legal age of 16 years, with consequent complications of delivery and increased risk of maternal mortality. Female genital mutilation is still widely practised, though clinicians believe it has declined in the last decade; 97% of married females have undergone this procedure, according to a government survey (*1*). Health personnel are forbidden to practise female genital mutilation, though it is it expected that this tradition will be continued informally.

Egypt has one of the best networks of countrywide basic health services available in developing countries, covering 99% of the population (*2*). There are about 4000 primary health care services all over the country, and about 80% of their clients are women and children. However, only 29% of the health budget is allocated for preventive services, and the quality of the services provided needs to be improved. The health sector in Egypt is in transition: taking into consideration high inflation rates and the structural adjustment programme promoted by the World Bank and the International Monetary Fund, it is expected that household expenditure on health will be reduced in order to face other basic needs.

Reproductive health cannot be separated from health conditions in general. For example, anaemia in women may be caused by reproductive functions, malnutrition, parasitic diseases, or a combination of all three. Reproductive health is a major issue in Egypt's health policy: contraceptive use is 48%, and mass media campaigns have helped to raise public awareness about various diseases. Pregnancy and childbirth are seen as natural events not requiring help from the health services, so only 40% of pregnant women request antenatal care. Women of low socioeconomic status tend not to attend an antenatal clinic unless they have problems, whereas middle-income women do so for confirmation of their pregnancy. About 46% of women receive medical assistance at delivery, traditional birth attendants (*dayas*) being culturally more acceptable than physicians. The Ministry of Health runs training programmes for *dayas*, to lower the risk of maternal mortality.

Women's empowerment is a slow process, and women decision-makers are rare. Only 2% of parliamentary seats are held by women. Few women exercise their right to vote: studies show that they are more likely to do so if they live in rural areas, but that they vote as directed by their husbands. Over a quarter of professional and technical workers are women, but only 16% of administrators and managers. This is partly because women are often torn between their double responsibilities of work and home. Labour laws require the establishment of nursery facilities at workplaces employing more than a hundred women, but they are sometimes not followed.

In recent years many nongovernmental organizations have focused on the issue of empowering women, but few of them realize the importance of a comprehensive approach to women's health. Medical technology is available for the prevention and control of diseases, but we now have to shift to the more difficult task of health education and awareness raising. ■

Salma Galal
Professor of Community Medicine
23 Sh. Abdel Kader el-Maghrebi
11351 Heliopolis-Cairo
Egypt
tel/fax: 00202 2433326
e-mail: hashem@mboxes.com

References

1. *Egypt demographic and health survey 1995*. Cairo, National Population Council, 1995.
2. **United Nations Development Programme.** *Human development report, 1994*. New York, Oxford University Press, 1994.