Lesotho

General Information

Lesotho is a country with an approximate area of 30 thousand sq. km. (UNO, 2001). Its population is 1.8 million, and the sex ratio (men per hundred women) is 87 (UNO, 2004). The proportion of population under the age of 15 years is 39% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 73.7% for men and 90.3% for women (UNESCO/MoH, 2004).

The country is a low income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.5%. The per capita total expenditure on health is 101 international $, and the per capita government expenditure on health is 80 international $ (WHO, 2004).

The main language(s) used in the country is (are) English and Sesotho. The largest ethnic group(s) is (are) Sesotho. The largest religious group(s) is (are) Christian.

The life expectancy at birth is 32.9 years for males and 38.2 years for females (WHO, 2004). The healthy life expectancy at birth is 30 years for males and 33 years for females (WHO, 2004).

Epidemiology

In a small community based study done in 2001, that involved all adults in a small lowland town, depression (10%) and anxiety (8%) were found to be common. The female to male ratio was 3:1. These rates were deemed similar to levels observed in the neighbouring country – South Africa (Makara, 2004). Hollifield et al (1990) interviewed adults in a village to determine the community prevalence of major depression, panic disorder and generalized anxiety disorder using the Diagnostic Interview Schedule. There was a significantly higher prevalence of all three diagnoses in Lesotho as compared with the United States. Women were at an increased risk for these disorders, although statistical significance was not demonstrated for depression. In an inpatient sample (year 2002), the point prevalence (n= 376) of mental disorders was as follows: 29% had cannabis related mental disorders, 20.2 % had psychotic disorders, 17% had schizophrenia, 9% had organic mental disorders, 7.2% had bipolar mood disorders 6.4% had depression and 6.1% had alcohol related disorders. A similar audit of outpatients (year 2003) showed that about one-third of patients had epilepsy related diagnosis and 17% had depression. Depression was five times more common in women in comparison to men. Schizophrenia (14.6%) and alcohol and drug related mental disorders (9.3%) were also common (Makara, 2004). Hollifield et al (1994) conducted a study in the outpatient clinic of a general hospital to assess depression, generalized anxiety and panic disorder using a translated version of the Diagnostic Interview Schedule and DSM-III-R criteria. Out of the 126 randomly selected out-patients the researchers found that 23% had depression, 24% had panic disorder and 29% had GAD. Forty-six (36%) had either depression or panic disorder, with thirteen having concurrent illness. Patients with depression and/or panic disorder presented with a significantly higher number of physical symptoms and a higher percentage of symptoms that were pain or autonomic nervous system related than patients with no disorder ever. As part of a larger baseline survey of community health status, Siegfried et al (2001) randomly sampled households in 29 villages. Consenting adults (n=348) participated in a face-to-face interview about alcohol use, which included the CAGE. Blood was taken from participants for CDT determination.53% of men (37/69) and 19% of women (53/279) reported drinking alcohol. 36% of men and 9% of women were found to have

hazardous patterns of drinking as per predefined criteria. Hazardous drinkers were significantly more likely to be male and older. Using hazardous drinking as the standard, CAGE (score >=2) had a positive predictive value of 75% for men and 62% for women. CDT values also showed high specificity. Meursing and Morojele (1989) conducted a study to ascertain degree of alcohol consumption and attitudes and knowledge of alcohol use among 1133 high school students aged 11-22 years. They primarily used a questionnaire but additional information was obtained by means of classroom discussion and detailed interviews. About half of the students (54% of the boys and 42% of the girls) had drunk alcohol at some point in their lives. Drinking was found to be related to age, sex, drinking of friends, family income and drinking in the family.

Mental Health Resources

Mental Health Policy

A mental health policy is absent.

The mental health policy is in the draft stage. It is likely to be adopted in 2005.

Substance Abuse Policy

A substance abuse policy is absent. The substance abuse policy is also in the draft stage.

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1964.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is absent.

Mental Health Legislation

There is the Mental Health Law No. 7. It is being updated.

The latest legislation was enacted in 1964.

Mental Health Financing

There are budget allocations for mental health.

The country spends 7% of the total health budget on mental health.

The primary source of mental health financing is tax based.

The country has disability benefits for persons with mental disorders. Psychosocial assessment is done and needy patients are being financially supported. However, this is in some areas only.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. The primary level care is provided through health

centre/clinics where mental health services are integrated into the general health care and are carried out by general nurses with support and supervision from psychiatric nurses from local hospitals.

Regular training of primary care professionals is carried out in the field of mental health. There is a continuous medical education programme for mental health workers at secondary care level (psychiatric nurses and medical officers). Community health workers are trained in four project areas and in future this will be extended to other areas.

There are community care facilities for patients with mental disorders. Community care is available through health posts where integrated services are carried out by community health workers. Support is also provided by mobile units comprising of psychiatric nurses and by resident social workers.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	0.8
Psychiatric beds in mental hospitals per 10 000 population	0.3
Psychiatric beds in general hospitals per 10 000 population	0.5
Psychiatric beds in other settings per 10 000 population	0
Number of psychiatrists per 100 000 population	0.05
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.2
Number of neurologists per 100 000 population	0
Number of psychologists per 100 000 population	0.09
Number of social workers per 100 000 population	1.2

Mohlomi Hospital is the national main referral hospital with 60 beds. Services are delivered by a multi-disciplinary team consisting of 1 psychiatrist, 2 psychologists, 3 social workers, 3 occupational therapists and 20 psychiatric nurses. Secondary level care is available though 9 Treatment and Observation Units attached to General Districts Hospital and is provided by psychiatric nurses. There is only one psychiatrist for the whole country but psychiatric nurses receive in-services training (workshops) once a year in order to effectively manage patients.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. The Christian Health of Lesotho (CHAL), the main partner in health service provision is also involved in all mental health care services including promotion, curative and rehabilitative services.

Information Gathering System

There is mental health reporting system in the country. Mental health statistics are integrated in the Health Management Systems collected daily and reported monthly for compilation and

analysis. Annual Statistics are published regularly together with other statistics generated by the Ministry of Health and Social Welfare.

The country has data collection system or epidemiological study on mental health. Service data collection is present.

Programmes for Special Population

A proposal supported by the African Development Bank Project for specialized services for children, elderly and forensic patients has been developed. These services will be initiated in the year 2005.

Two Drug and Alcohol Rehabilitation Centres based in the city of Maseru offer services for clients with problems related to substance abuse.

Therapeutic Drugs

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

The therapeutic drug policy is in the draft stage. Anti-psychotics and anti-epileptics are given free to the indoor and outdoor patients. Carbamazepine, ethosuximide, fluphenazine, haloperidol, lithium and biperiden are available at the secondary level of care and sodium valproate is available at the tertiary level. All of the above mentioned drugs are in the drug list.

Other Information

The Government of Lesotho adopted the strategy of primary health care in 1979. The country is divided into 18 Health Service Areas based on catchment areas of 18 hospitals that supervise 165 satellite health centres. The health centres in turn supervise Village Health Workers at community level. Almost half of the health facilities are owned by the Christian Health Association of Lesotho (CHAL). The complimentary services delivered by CHAL and the Government covers almost 80% of the population (i.e. almost 80% of the population lives within 2 hours walking distance form a static health facility). A resident Fly Doctors Service covers inaccessible mountain areas.

Additional Sources of Information

•Hollifield, M., Katon, W., Morojele, N. (1994) Anxiety and depression in an outpatient clinic in Lesotho, Africa. International Journal of Psychiatry in Medicine, 24, 179-188.

•Hollifield, M., Katon, W., Spain, D., et al (1990) Anxiety and depression in a village in Lesotho, Africa: a comparison with the United States. British Journal of Psychiatry, 156, 343-350.

•Makara, M. (2004). Information on Lesotho Mental Health Profile. (Personal Communication)

•Meursing, K., Morojele, N. (1989) Use of alcohol among high school students in Lesotho. British Journal of Addiction, 84, 1337-1342.

•Siegfried, N., Parry, C. D. H., Morojele, N. K., et al (2001) Profile of drinking behaviour and comparison of self-report with the CAGE questionnaire and carbohydrate-deficient transferring in a rural Lesotho community. Alcohol & Alcoholism, 36, 243-248.