and accountability. These factors need also to be taken into account in mental health policy, legislation and implementation for the well-being of the Congolese population.

The national mental health programme needs to be allocated a government budget so that it can be implemented. It will then be possible to begin to work towards mental health promotion, training in mental health for staff at all levels, epidemiological research, improvement of infrastructure, effective integration of mental health in primary care, and liaison with family, traditional and religious healers in the management of people with mental problems.

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ORIGINAL PAPER

Community mental health provision in Pemba Island, Zanzibar: a cross-sectional survey of different stakeholder groups

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There is limited information about stakeholder perceptions of health service provision in low- and middle-income countries. We conducted a cross-sectional survey of 821 stakeholders of the community mental health services in Pemba Island, Zanzibar, Tanzania. The aim was to obtain systematic information about coverage, barriers, accountability and room for improvement as a baseline before implementation of a new mental health policy to strengthen mental health services.

Zanzibar lies off the coast of Tanzania in the Indian Ocean and consists of two main islands, Unguja (Zanzibar) and Pemba. It has served as a gateway into East Africa for traders from Arabia, Asia and Europe. Pemba has an area of approximately 900 km^2 and an estimated population of 500 000 (National Bureau of Statistics Tanzania, 2002).

A community mental healthcare programme was instituted for Pemba in 1994, to improve the detection and treatment of mental health disorders. However, there was no assessment of whether this was systematically established throughout the island. We therefore conducted a baseline cross-sectional survey to study the views of major stakeholders about available facilities, staffing and medication through the community mental health services in Pemba, in order to assist the further development of services and implementation of the new mental health policy.

Method

The sampling frame consisted of three groups of residents of Pemba Island:

- community leaders and members
- health workers and traditional healers
- people attending psychiatric out-patient and general medical departments, either as users presenting with mental health problems or as carers.

A questionnaire was used to collect information on: sociodemographic details; views of current provision of mental health services; explanations of the different disorders; views on treatment; views on traditional healers; and views on

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what could be done to promote mental health in Pemba. The views of users, carers and traditional healers about explanatory models for mental health problems have been reported elsewhere (Mirza *et al*, 2006).

From February to May 2001, participants were recruited from the out-patient department of the three-district referral hospital of Pemba Island, the psychiatric admission ward at Chake-Chake hospital and the consulting rooms of traditional healers. Consecutive patients were interviewed together with their relatives. The chairman of the traditional healers' association gave permission to conduct the survey among the association's members and provided a current list of healers in Pemba. A convenience sample was obtained both for traditional healers and for other stakeholders. Verbal consent was obtained prior to interviews.

Results

A total of 821 persons were interviewed. Their mean age was 37 years (95% CI 36, 38 years). There were 496 (60%) men and 311 (38%) women; 590 (72%) were married. Sociodemographic details according to category of stakeholder are given in Table 1.

The majority (range 50–84%) of respondents from all but one of the groups of stakeholders reported a lack of community mental health provision in their area; the exception was the group of carers, just under half of whom (46%) reported a scarcity of this resource (Table 2). Among those who described this shortage, a major reason reported was lack of staff, cited by 69% of traditional healers, 42% of community members and 42% of community leaders, whereas health workers cited no interest from families (26%). There was little comment from users or carers about the reasons for this, as only 3% reported lack of staff, whereas others who had reported lack of facilities did not state any reasons for this. Of those who reported that services were present in their area, the majority of each stakeholder group reported that out-patient (range 61–96%) and counselling (range 48–86%) services were available, whereas very few had knowledge of any outreach services.

A majority (range 62–91%) reported a lack of availability of psychotropic medication, except for community leaders (36%). Similarly, the majority of each group (range 74–93%), except again for community leaders (41%), felt that the provision of psychotropic medication was the responsibility of the Ministry of Health.

All stakeholder groups reported that health workers had never visited their communities in order to undertake mental health activities (range 87–99%). The involvement of community members and leaders in the treatment and prevention of mental health problems was either the most or the second most frequent need mentioned by all the groups (detailed breakdown available on request).

Discussion

Our findings indicated that all stakeholders consider there is a need to improve coverage of existing services, and identified lack of space, trained personnel and mental health literacy as key barriers. There was considerable support among

Table 1 Sociodemographic profile of the study participants

	Community		Providers		Users and carers	
	Community members	Community leaders	Traditional healers	Health workers	Users	Carers
Number in sample	151	169	119	145	107	130
% of total	18.4	20.6	14.5	17.7	13.0	15.8
Health community, *n*						
Mkoani	3	10	7	41	3	1
Chake-Chake	98	122	100	31	91	107
Wete	42	29	7	35	10	20
Micheweni	4	0	0	38	3	2
Mean age (years) (95% CI)	36.0 (34, 37)	41.2 (39, 43)	50.6 (48, 53)	33.4 (32, 35)	30.9 (29, 33)	31.7 (30, 33)
Gender, *n*						
male	71	135	101	81	50	58
female	76	31	16	62	55	71
Marital status, *n*						
single	31	23	12	36	41	29
married	112	136	100	98	52	92
divorced	7	2	5	9	12	6
widow(er)	1	0	1	1	2	3

Table 2 Views on level of available community mental health services and treatments in the locality

	Community members ($n = 151$)	Community leaders ($n = 169$)	Traditional healers ($n = 119$)	Health workers ($n = 145$)	Users ($n = 107$)	Carers ($n = 130$)
Lack of mental health services in their area	126 (84%)	106 (63%)	59 (50%)	100 (69%)	58 (54%)	60 (46%)
Never had community visit by health worker in relation to mental health	148 (98%)	147 (87%)	112 (94%)	131 (90%)	106 (99%)	125 (96%)
Lack of psychotropic medication	111 (74%)	61 (36%)	103 (87%)	133 (91%)	66 (62%)	114 (88%)
Ministry of Health responsible for supply of psychiatric medication	112 (74%)	70 (41%)	98 (82%)	114 (79%)	96 (90%)	121 (93%)

stakeholders for community mobilisation, and they thought that the Ministry of Health was responsible for the promotion of mental health services.

The strengths of this study are its relatively large size and its inclusion of multiple stakeholders. The findings are limited, however, by the possibility of response bias and selection bias, as it was a cross-sectional survey of consecutive consenting users and carers and a convenience sample of other stakeholders.

Our study showed that users, carers, providers, community members and leaders recognised the need to improve the coverage of community mental health services in order to improve outcomes. The high proportion of users reporting lack of knowledge of availability of services highlights the huge treatment gap for mental health, which is not uncommon in low- and middle-income countries (World Health Organization, 2008). A greater proportion of providers than users reported that psychiatrically trained staff were available. The users' and carers' relative lack of knowledge may be partly due to poor access, as all groups reported a lack of community psychiatric outreach work at the time of the survey. This lack of skilled staff and a lack of psychotropic medication at the community level have been previously described as a significant barrier to the improvement of community mental healthcare (Saraceno *et al*, 2007).

Our study found that there was considerable goodwill for community participation in dealing with mental health problems, as the majority identified the need to involve community resources such as community members, police, and traditional and religious healers in the treatment and prevention of mental illness. They recognised that the resources for mental health are scarce, and this presents an opportunity to educate and involve these stakeholders in public health interventions targeting mental health. Therefore future work needs to include both community education and education of primary care teams to integrate mental health into primary care provision. Evidence from projects in Africa suggests that this is feasible, but requires sustained commitment from the Ministry of Health and local professional organisations (Muga & Jenkins, 2008*a*,*b*).

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ORIGINAL PAPER

Use of translated versions of the MMSE with South Asian elderly patients in the UK

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The elderly population is increasing all over the world, a trend expected to continue well into the next century, particularly in low-income countries (Levkoff *et al*, 1995). There is an established association between increasing age and cognitive decline (Fillenbaum, 1984) and dementias are common in this age group.

Many South Asian people migrated to the UK in the 1950s and 1960s, mainly as young adults, to meet the demands of a growing labour market. Initially, therefore, older people constituted a relatively small proportion of the UK's South Asian population. However, this proportion is now expected to grow (Rait *et al*, 1996).

South Asians in Britain are a heterogeneous group, with different religions, languages and cultures. Their mental health needs have been investigated to a lesser extent than their physical health needs. In this respect they have been disadvantaged by communication difficulties and other barriers to diagnosis, lack of culture-sensitive research, poor access to psychiatric services (Manthorpe & Hettiaratchy, 1993) and the traditional stigma attached to mental illnesses in their communities (Rait *et al*, 1996).

To diagnose dementia it is necessary to have a valid and reliable tool with which to assess cognitive function. However, sociocultural factors may complicate both the use of these tools and the interpretation of their results (Kabir & Herlitz, 2000). Efforts have been made to improve the validity of instruments used to screen for dementias by producing adapted and translated versions for different cultures. Adapted and translated versions of the Mini-Mental State Examination (MMSE; Folstein *et al*, 1975) have been developed in five South Asian languages commonly spoken in the UK – Bengali, Gujarati, Hindi, Punjabi and Urdu (Ganguli

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