REVIEW ARTICLE

MENTAL HEALTH CHALLENGES AND SOLUTIONS IN LOW AND MIDDLE INCOME COUNTRIES –A HEALTH SYSTEM PERSPECTIVE

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ABSTRACT

There are many gaps in establishing an active mental health system in low and middle income countries. In this article we have reviewed multiple studies focusing low and middle income countries to explore the barriers, challenges, solutions and opportunities regarding improvement of mental health system in these countries. Literature emphasizes political with good financing ,effective policies ,multi-sartorial and holistic approach encompassing linkage between health and non-health sectors leading to equitable access of mental health to populations in low and middle income countries.

Keywords: Health care systems, Health policy, Low-income countries, Mental health.

INTRODUCTION

A health system can be defined as "the sum of all the organizations, institutions, and resources whose primary purpose is to improve health". A reasonably operative health system must provide quality services to everyone, in each hour of their need[1]. It must safe guard everyone's right to health, encompassing mental, neurological, and substance use (MNS) disorders[2,3]. All over the globe Low and Middle Income Countries (LAMIC), including whole of Africa, most of Asia, South and Central America, Island states of pacific and East Europe, comprise of 80% of the world population. However research on mental health, publishedin indexed journals from these countries is merely 6%[4]. The World's Development Report 1993 and the subsequent Global Burden of Disease report's comparison of health conditions based on combined disability and mortality data has increased concerns of International public-health for mental health[1,5,6]. The findings of these studies revealed that in rich as well as in LAMICs mental disorder simposed greater burden of disease, which was a shocking fact for many from the International Public Health field. However these reports did not bring forth any explicit policy recommendations. Statistics of global burden of disease provoked three prominent international reports[7-9] and several significant regional and national reports[10-15]. All European health ministers including 27 from low and middle-income countries of Eastern Europe signed one of these regional reports. They committed themselves to execution of a thorough service development plan, prevention of mental illnesses, and enhancement of wellbeing[15]. As compared to burden of disease financing for mental health is meager globally and due to different barriers mental health interventions could not be scaled up with a parallel shortage of specialized staff imparting supervision and support[16]. The international advanced reports invited decision makers to put all possible efforts to arrange care for those suffering from mental disorders. These reports were mainly concerned about the wellbeing of sufferers of mental disorders. Role of social factors in mental disorders and wellbeing was extensively studied in one of them[3,7], another focused on epidemiology and interventions for specific neurological disorders[4] yet another concentrated especially on mental health policies and services[9]. Recommendations offered in these reports regarding mental health

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service are largely synchronized. Two kinds of recommendations on services were made. One type recommendations are to enhance handiness of care and second type are regarding components of mental health system to facilitate delivery of improved care, for instance improvement of human resources or modifications in mental health policy, Lancet Series studied epidemiological proof[17]. Health systems are often unsuccessful to fulfill the requirements of persons with MNS disorders. They are particularly overburdened in LAMICs, due to lower availability of human and financial resources and greater overall load of disease in these populaces than that of high-income countries. Three-quarters of the global disease burden is attributable to effects of MNS disorders in LAMICs[18]. In advocacy of global mental health in present scenario the World Health Report (2001) is ranked as the most valuable document[19]. The above mentioned three documents have foundation in rich research evidence from LAMIC, which remained markedly unnoticed by the global health community. Research at large scale has been published,since then, documenting mental health in developing countries from various dimensions. It will be thoroughly reviewed in the upcoming Lancet series on global mental health[20]. Research published since 2001 is selectively analyzed in this journal'sreview. The review focuses on frank mental disorders; however, the author highlights the fact that these disorders are often superfluously defined on grounds of existing symptoms of mental illness exceeding from a pre-determined threshold, this threshold varies in different situations[21].

Challenges

A range of international specialists and leaders were surveyed in order to know the challenges in the way of betterment of quality and accessibility of mental health in most low and middle income countries[22]. Insufficient funding for mental health services was reflected in results. Inconsistent and ambiguous propagation is the major reason that funding authorities are not convinced to contribute. Inadequate perception regarding weakness of mental health indicators also results in deficient funding for mental health. Presently people with mental illnesses are not adequately strong lobby to influence the scenario. Identifiably general public has lack of interest in mental health. In addition social stigmatization of mental health and wrong belief regarding its care as not being cost effective dismays the funding agencies. Mental health resources are located either in or near big cities and in big institutions. The reason behind is the historical dependence of the masses on mental hospitals. Division of mental health responsibilities among government departments also results in centralization of resources. There are disparities between central and provincial government priorities. Potential factors for pooling of resources at one place include, vested interest of professionals and workers of mental health in connection with large hospitals and political endanger linked with trade union protests. The already over burdened primary-care workers lead to marked intricacies to effectively integrate mental health care in primary-care services. After training the working staff experiences lack of supervision and specialist support. The integration becomes more complex due to lack of constant supply of psychotropics in primary care. Another barrier for good governance of mental health system is the less number and restricted types of trained and supervised health workers in mental health care. Factors involved in poor human resource in mental health include, inadequate work place conditions in public mental health services, little incentives for working in rural areas, opposition of professional establishment for expanded role of non-specialists in mental health workforce. Medical students and psychiatric residents are trained in mental hospitals only. General health workforce is inadequately trained. Mental health specialists give less time to training and supervision of

others than that of provision of care. Infrastructure also lacks for enabling community-based supervision. There is often deficiency of public health skills and experience in mental health leaders. They are often trained in clinical management only. Mental health training is not included in public-health. Psychiatrists are resistant to accept other's leadership. Situation is further made vulnerable due to lack of training courses in public mental health. There is hardly any contribution to systemic changeby leaders due to over burden of their clinical and management responsibilities and private practices[23]. In low-income countries especially in sub-Saharan African (SSA)countries, resources for health are extremely low than those of the developed world. 33 member states of World Health Organization (WHO) in SSA spend lesser than US $50 per capita annually and 11 of these spend lesser than US $10 per capita annuallyon health[24]. On contrary, in 2008 total expenditure on health per capita in the UK and the USA was US $3129 and US $7538 respectively[25]. The burden of most non-communicable disorders (NCDs) including mental disorders is fast raising in low-income countries. It is attributed to changing lifestyles and diets[26,27]. Along with mortality, morbidity and economic costs are the constant challenges[28]. Mental health represents 8% of the disease burden in high-mortality low-income and middle-income countries, despite that it does not receive any specific health budget in most African countries. Less than 1% of the health budget is allocated to mental health in the vast majority of the countries, having a specified budget[24]. Rate of repeated consultation is higher among patients with mental disorders if they are undiagnosed and untreated, it adds to the burden on health systems. It was found in a study that 44.8% of patients attending a health center in Nairobi, Kenya had psychiatric morbidity of pre dominant anxiety and depression. Despite repeated consultations over time the primary care workers misdiagnosed all of them[29]. It has been observed that mental illnesses are a vital determinant of poverty and a main source of disease burden in low-income and middle-income countries. Although a great part of this morbidity and mortality is potentially avoidable but it remains unnoticed at a large scale. It is quite contrary to major communicable diseases like HIV, malaria and tuberculosis, which have taken advantage from considerable international financing since 2002. Health policy makers of both international and domestic level have confronted a number of conflicting demands leading to prioritization of a few disorders only instead of adopting inclusive public health approach. Historically mortality data in fluenced disease priorities. However it over looks co-morbidities and does not takes the fact into consideration that deteriorated mental health is a triggering factor for early mortality from physical disorders. There is an increased rate of HIV and tuberculosis people with mental health problems. It is also found that victims of HIV and tuberculosis pass through a higher burden of mental illness[30,31]. Therefore while making policy decisions about prioritizing health care only mortality should not be focus edmorbidity should also be considered, morbidity is important due to connected health conditions. Further more factors of illness and extensive economic costs associated with untreated conditions should also be considered, for example mental illnesses that are avoidable and their treatment brings benefits for individuals, their families and the broader economy[32].

Health system is not well established in Pakistan as there is lack of sufficient resources. Community work is restricted to limited number of tertiary care hospitals and to big cities only. In community based psychiatric inpatient units for children and adolescents, only 1% of 1.926 beds per 100,000 populationare available. Community based residential facilities and out-patient treatment facilities are unavailable in the country. There is insufficient training at the graduation level. There is

insufficient distribution of human resources between urban and rural areas which is disproportionate. In or around the largest city the density of psychiatrists is 2.29 times higher than thedensity of psychiatrists in the entire country. In government sector there is considerably low density of clinical psychologists and socialworkers. Social insurance schemes do not cover even a single mental disorder. Government health department has specified only 0.4% of health care expenditures to mental health. Only 11% of all the expenditures spenton mental health are allocated to mental hospitals. Implementation of existing legislative and financial provisions to protect and provide support to users is inadequate. Inequity prevails to access mental health services[33].

Solutions

The importance of the new approach based on the impact of mental health on human, social and economic capital of countries is rightly highlighted by Wahlbeckas an entry point to introduce mental health issues in the political agenda[34]. Information on social and economic determinants can be used to contribute to the improvement of mental health in terms of informing service planning, organizing programs for promotion and prevention and influencing authorities outside the health sector for taking initiatives to promote mental health[35]. In low-in come countries mental health integration into non-health policies must be prioritized and actively pursued. Effectiveness of innovative models of integrated care has been proved.The provision of accessible, comprehensive and co-ordinated services is needed to address the challenges faced to integrated care[36]. For influencing the behavior of policymakers studies have suggested creation of incentives and norms[37]. An important consideration in psychiatric services is the implementation of evidence based interventions in mental healthcare. It would be an improvement to provide evidence based practices even under restricted conditions as it would create awareness among stake holders regarding potential of other evidence-based practices. For instance, it has been found that vocational outcomes do not consistently improve by assertive community treatment and in order to achieve high rates of competitive employment, supported employment must be a well-integrated component of the intervention[38]. In few countries consensus-based national mental health plans have been written in consultation with key stake holders, inclusive of non-governmental organizations, clients and consumers representatives, and sectors other than health. By operationalizing asynchronized proposal for services, a well-established national plan for mental health, developed in aparticipatory manner by the government, and all key stakeholders, can result in progress[39]. Improvement of secondary care-level community mental health services should be prioritized and already available formal and in formal resources in the community should be used by the people responsible for service development[23]. Deinstitutionalization and decentralization of resources is needed. A core strategy is inclusion of mental health into the basic set of essential health services, specifically those provided by primary care. It would involve few additional national costs, related to other program areas[16]. Recent mental health policies have stressed the prime significance of integration of mental health into primary care for making mental health care accessible to the population.[9,40]. With adequate political will to enhance availability of and access to humane mental health caremany of the hindrances in development of mental health services can be overthrown[23]. In this context political will refers to the inclination, molded by beliefs or incentives for policymakers to take action for makingor blocking change[41]. Secondly there are greater chances for the success of propagation for mental health services if it incorporates much required research on the factors involved in shaping political will. Third, development of secondary

care-level community mental health services must be prioritized. Fourth, much more effective utilization of already existing formal and informal resources in the community by the people responsible for service development is needed. In Pakistan the new ordinance related to mental health is an appropriate response to changed social and professional attitudes.The Universal Declaration of Human Rights and its extension regarding mentally disabled individuals can be a useful guide to action. Inclusion of psychiatry as a distinct subject in the medical curriculum can assist future doctors in identification and to some extent treatment of mental health issues. In national health system no psychotherapist is currently working in Pakistan. Collaborative work with trained clinical psychologist can play a significant role[23].

CONCLUSION

Financial allocations are very less as compared to global burden of mental health issues. Limited planning and deficient health policies lead to inadequate and in equitable access of mental health care in low and middle income countries. Mental health system as a part of public health system should be integrated as multi-sectorial phenomena. Up scaling evidence-based mental health interventions requires all the levels and components of the health system working together encompassing policies, politics, leadership participation, planning and advocacy. This linkage is key to the attainment of an equitable and accessible mental health care delivery.

CONFLICT OF INTEREST

This study has no conflict of interest to declare by any author.

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