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THE MHGAP; WILL IT BRIDGE THE MENTAL HEALTH TREATMENT GAP IN PAKISTAN?

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ABSTRACT:

In Pakistan, the treatment gap for mental disorders is significantly high. Pakistan faces a unique problem of sustainable delivery. In 2009, WHO launched a mental health gap action program (mhGap) to provide evidence-based services at the primary and secondary level for the prevention and management of psychiatric and neurological disorders. This article highlights the discrepancies of the systems and issues related to mental health services provision in Pakistan. By discussing two initiatives of mhGap implementation for the Pakistani health system, authors have surveyed core areas where the sustainability of such a model can be compromised. The structural challenges marked by the stresses of an economy under pressure, poverty, health disparities, weak administration, allocation of resources and stigma attached to MNS exacerbated by both natural disasters and geopolitical crises make implementation an ongoing challenge. Despite these challenges, in recent years, Pakistan has taken positive strides to start the conversations at leadership and the professional landscape, a trend that is likely to continue. The various components of public and private healthcare systems have remained inadequate to reduce this treatment gap. To create and maintain the momentum, support in terms of capital resource, human resources, infrastructure, and need for advocacy at governmental and non-governmental levels is necessarily required.

INTRODUCTION: Pakistan is ranked as 146th out of 187 countries in the United Nations Development Program's (UNDP) human development index (HDI). [1] Health care delivery system includes public, private, civil society, and philanthropic contributions (Figure 3). The private sector attends 70% of the population. Under the article 18th amendment to the Constitution of Pakistan, the health care services are the obligations of the provisional government except for the federal area. The public health delivery system comprises of three-layered approach primary, secondary, and tertiary.[3] Moreover, there is a non-existent system of referral by primary care to secondary or tertiary care. Rural and poor households rely heavily on the private sector for ambulatory care. Surveys by CIET [4], which covered a sample of 57,000 households in all districts of the country, indicate that in 2005, 74 percent of very vulnerable households typically used private services. The mean cost to the user per visitation in public and private providers is comparable.[5] Even though the state covers the costs of government services, nearly all users of government facilities pay out of pocket. These expenses include primarily of payments for medicines bought outside the facility. Around 96% of users of public facilities claim to make such payments. Their payments, on average, are 35 percent of the monthly per capita income in Pakistan.[6] In terms of health expenditure, the health sector gets minimal priority in the public policies and allocation decisions of the investment funds in Pakistan. In particular, public sector health expenditures as a percentage of GDP have not only remained immensely low but have also been falling consistently since the 1990s. According to the World Bank, Pakistan spends 2.6 % of its GDP on health, which is around 7.6% of total government spending (15 US$ per capita); this is significantly lower than countries with similar income indices, e.g., Senegal (39 US$ per capita). [7]

Mental health services are not well organized, such as catchment/service areas like National Health Service, United Kingdom (NHS, UK). The treatment of mental health disorders is not covered by social insurance schemes and third payment even if it exists; it does not cover for the medication cost or hospitalization. [8, 9] Consulting a psychiatrist is still seen as a stigma with harmful social and occupational consequences. The cost of antipsychotic medication is two dollars per day, and the cost of antidepressant medication is five

dollars per day. [2] In 2006, the economic burden of mental illnesses in Pakistan was Pakistan Rupees (PKR) 250,483 million (USD 4264.27 million). [9] The patients are mainly looked after by their families in Pakistan. The distribution of resources between urban and rural areas is disproportionate [10]. The number of psychiatrists in or around the largest city is 2.29 times greater as compared to the entire country. [2] The number of nurses is 0.15 times higher in urban cities. The density of clinical psychologists and social workers, working in the government sector is quite low. [11] Less than 1% of the total health care expenditures by the Government Health Department are devoted to mental health.[8]. 11% Of all the mental health expenditures are devoted to mental hospitals. These centers have no preventive services, and the bulk of work is curative tertiary health care delivery, in outdated, archaic facilities. The critical time is lost for early intervention by the time patients present to these centers. [12] Out of the six hundred and, twenty-four (624) Community-based psychiatric inpatient units are located in urban centers with little coverage for 65.7% of the population who live in rural areas (67.5%). (2, 13) A study conducted in 2006 points to significant gaps in basic amenities, indicating that on average only 46% of first level health care facilities had a water supply, 72 % had electricity, and 33% had public toilets. Staff absenteeism is as high as 63 % for some categories of health professionals. Day treatment facilities or rehabilitation centers which look to accommodate the individuals to build psycho-social and vocational skills are not available in the country. A significant number of first level health care facilities are in poor condition. The mental health training of medical students is limited, as the majority of schools do not have a mandatory undergraduate psychiatry curriculum. [14] Handful institutes have psychiatry clerkship as a mandatory rotation.[15] There are significant inadequacies in undergraduate as well as postgraduate training, with a shortage of qualified specialists [16] With 130 medical schools, the country graduates around 15-to-20,000 students every year. These students are unlikely to choose psychiatry as a specialty due to lack of exposure, which further increases the treatment gap, whereas clerkships in psychiatry can also positively impact students outlook and attitudes towards psychiatry. [17] In terms of active clinical practice, there are around 110,000 primary care physicians in the country [18]. The number of professionals who graduated last year in academic and educational institutions (per 100,000) is as follows:

Medical doctors (not specialized in psychiatry): 2.1
Nurses (not specialized in psychiatry): 1.5
Psychiatrists: 0.002
Psychologists (least 1-year training in mental health care): 0.07
Social workers (least 1-year training in mental health care): 0.005
Occupational therapists with at least 1-year of training in mental health care: 0/002

1-20% of psychiatrists immigrate to other countries within five years of the completion of their training [19]. Common reasons for moving abroad are lucrative salary, quality of training, job satisfaction, the geopolitical situation in Pakistan, better management and systems, peer pressure, and longer working hours.

Mental Health Treatment Gap (mhGap):

It is well known that health care provision in various parts of the world varies in terms of both quality and accessibility. The term "treatment gap" is the difference between the number of people with mental health disorders and the number of those people who can access appropriate services. [20] The gap is more so visible in low resource and low-income countries, especially lacking in infrastructure and development. [21] As a step towards bridging the treatment gap, WHO launched mental health gap action program (mhGap) in 2009 to provide evidence-based services at the primary and secondary level for the prevention and management of psychiatric and neurological disorders. The WHO mhGAP initiative is designed to fill the inadequacies in the delivery of care for low resource settings. The emphasis is on the principles of universal health coverage, human rights, evidence-based practice, a life course approach, a multi-sector approach, and empowerment of people with psychiatric and neurological conditions. It provides a framework encompassing the various facets of mental health care delivery beginning at situation analysis, setting up teams, budgeting, advocacy, involvement of various stakeholders including the health authorities, NGOs, patients and their caregivers, training and supervision of both physicians and paramedical staff, coordinating care pathways, improving access to psychotropic and psychological treatments, monitoring and evaluation (M&E) and data collection. [22] Various limitations are identified in the literature within the contents of the mhGAP in the context of developing countries. The mhGAP approach has been confronted as a symptom of a larger concern, i.e. the ongoing process of medicalization by Clark J et al. [23] It has been regarded as a "tertiary care approach," with biological treatment regimens based on evidence collected in high income,

western countries. [24] Excessive reliance on checklist diagnoses and management plans often overlooks unique culturally contextualized psychosocial stressors. It misses out, taking into account the health care beliefs and importance of local religious, spiritual, and faith healers' practice. In LMIC, socio-cultural determinants of mental health play a significant role [25]. For example, religion and spirituality are used as coping strategies in times of suffering, which can give meaning and purpose to one's experiences. [26] This makes a case of involving all stakeholders – including traditional healers - actively to promote mental health in LMIC [27].For reasons mentioned above, it is recommended that a process of country contextualization of the generic version of the mhGAP-IG before implementation should be done. In order to make effective use of the program, the application of every component is warranted. Several actions are recommended for the planning committees to implement this guide in non-specialized health care settings. This can be summarized in the following diagram which includes a number of essential actions and continuous activities. (Figure 1) A case study from Nigeria focused specifically on country contextualization of the Mental Health Gap Action Program Intervention Guide. [28]

Figure 1:

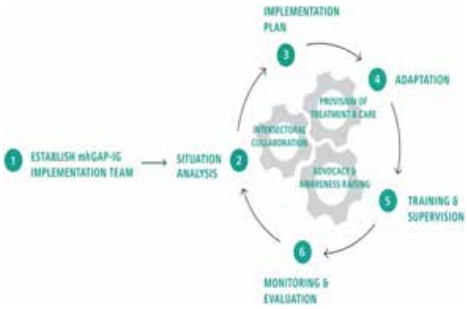

Figure 2:

Health expenditure in Pakistan (Rs. million).

Year	Total (millions) (Rs.)	% of GDP	External resources for health (% of total expenditure on health)
2000-01	24,281	0.58	0.90
2001-02	25,405	0.57	1.40
2002-03	28,814	0.59	1.80
2003-04	32,805	0.58	2.20
2004-05	38,000	0.57	2.50
2005-06	40,000	0.51	1.1
2006-07	50,000	0.57	3.0

(Source: World Development Indicators, World Bank 2006-07, Economic Survey of Pakistan 2006-7, Public Sector Development Programme 2006-2008).

Implementation of mhGap in Pakistan:

A critical analysis of 'The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS)' published in 2009 (2) revealed that despite mental health policy, plan and legislation in the country, implementation was lacking. In 2014, the first Mental Health Gap Action Programme (mhGAP) training was conducted for the internally displaced population in North Waziristan. [29] Training modules were developed for physicians and staff in the affected areas of North Waziristan after the launch of the military operation. This was the first instance of implementing MhGap guidelines in Pakistan following a humanitarian crisis. The similar project previously has been conducted in Srilanka. [30] It was neither a government nor an institutional led initiative but was coordinated by a group of mental health professionals volunteering their time and resources. The training process included the curriculum development, training of trainers (ToT), hands-on training workshops, supervision, and oversight on practice in the camps, and the establishment of a referral system. The mhGAP-IG was adapted to local mental health needs. The authors observed that the interface of the guide was found to be quite complex for Pakistani setting. It had to be simplified further: most of the training was designed and conducted in Urdu; a needs assessment was done to develop the curriculum which was guided by fieldwork; the primary emphasis of training was on psychosocial interventions; it was an integrated and module based teaching; included psycho-education, behavioral activation, stress management, problem-solving and supportive counseling. One main challenge faced by the training team was to introduce concepts of psychological medicine and psychotherapeutic interventions to an audience that seemed hesitant to invest in psychological interventions mainly due to concerns regarding investing their clinical time and expertise. Another challenge in terms of logistics of the project was lack of cooperation by the district health department due to the lack of recognition of mental health needs as a priority as well as security reasons. This barrier was overcome through the influence of the military authorities that had administrative control of the crisis zone. [31] A significant strength of this initiative was the collaborations between public health services (primary, secondary and tertiary levels) and humanitarian agencies to strengthen the existing local resources at all levels of the healthcare system.

The second initiative was in August 2017, a pilot project implementing mhGAP training in primary healthcare across five districts in Pakistan. Initial

planning workshop took place in August 2017 with objectives of reviewing the mhGAP training material, brainstorming on the next steps and having a roadmap for the cascade training in the selected Tehsils of the pilot districts. Four districts namely Hyderabad in Sindh, Quetta in Baluchistan, Rawalpindi in the Punjab and Peshawar in KPK were identified. Followed by this training, coordination meetings were held, at the federal and provincial level for integration of Mental Health Global Action Plan (mhGAP) into primary health care settings. The outcomes were outlines on training, supervision, and monitoring plan. As a follow-up, the respective provincial Governments would evaluate the pilot studies and scale up the integration of mental health in primary health care centers through developing and funding PC1s. [32]

Way forward:

We have described two initiatives and a process of contextualization and adaptation designed to make the mhGAP relevant and applicable to the context of Pakistan. There are significant challenges in implementing the WHO guidelines for the management of MNS conditions in Pakistan. The critical question is, how do we strengthen the existing system? Number of factors include: the low budget for health care in Pakistan; the scarcity of mental health practitioners; the stigma attached to psychiatric care; inadequate mental health facilities; limited awareness of mental health issues; illiteracy; negative concepts of mental illness; reliance on unproven alternative medicine; and low prioritisation of mental health by the government. [33] One of the key limitations identified and acknowledged by Humayun et al. (2006), included the absence of civilian agencies in the provision of healthcare facilities in times of humanitarian crisis. Implementation of such a highly structured program demands broad and long-term strategic directions for execution. The administrative onus of taking this initiative will be questionable in the context of Pakistan with unclear institutional jurisdiction in the 18th Amendment. There are a number of structural challenges; Political patronage, as well as limited administrative authority, that undermines the ability of lower-level administrative line-managers to link rewards and punishment to performance[34]; Lack of accountability in terms of healthcare delivery, corruption, physician training and appraisals, provision of medications, lack of health record maintenance [35]; Research based initiatives have low priority for the management [36]. Ecological data collected as a routine practice needs to be reviewed periodically for improvement in service delivery and audits. Moreover, these highlighted challenges require a concerted effort, public-private partnership to create a paradigm shift in mental health care delivery in Pakistan. Some essential components which need immediate attention and can be useful for the barriers mentioned above include:

Capital resources: One of the significant barriers in mental health services provision in Pakistan is the low budget allocated by the government. From the private sector, Pakistan is considered to be one of the most charitable nations in the world. This is evident in the form of health care projects supported by philanthropic organizations spanning the country free of cost for those who cannot afford them. There needs to be a far greater acknowledgment of the need for capital resources in policymaking and economic analysis.

Human resources: This is another area which requires simultaneous attention to improve the current situation. Consider an example where the administration of a tertiary care hospital has ample capital resources to establish mental health services. In the absence of physicians sensitized to mental health needs of the population, and lack of enough trained mental health professionals in the country, the quality of health care delivery will be not at the par. This cannot be a long-term solution for a current need. Hence it is crucial to develop required training programs to fill the void of human resources in the domain of health, education, and legal system.

Infrastructure: Above mentioned efforts related to capital and human resources will go in vain in the absence of required infrastructure. Policies, programs, and analyses that fail to acknowledge and account for infrastructures are likely to fail to address a critical dimension of health care delivery.

Awareness & Advocacy: It is essential to create awareness among masses about matters about mental health-related issues. Limited insight about one's rights and disparity are some of the barriers which hinder the access and provision of MH services. Constant advocacy for these matters at governmental and non-governmental levels is essential to create and maintain momentum continuously. A broader discussion is required in Pakistan on the state's attitude toward mental health disorders.

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