Mental Health Services in Low-Income Countries: Challenges and Innovations

Suman Fernando
Honorary Senior Lecturer in Mental Health,
The European Centre for the Study of Migration and Social Care, University of Kent
and Visiting Professor in the Department of Applied Social Sciences, London Metropolitan University

Abstract
Mental health service provision varies enormously across the world and faces major challenges, largely determined by the contexts in which it functions. A variety of services exist side by side in low-income countries. They include services provided in the statutory and private (fee-paying) sectors, therapies provided by physicians working within indigenous systems of medicine, healing provided at religious locations and services provided by non-governmental organisations. This paper provides a brief survey of some recent literature on mental health in low-income countries and goes on to describe a few examples of innovative projects in these countries. The paper concludes by outlining some of the challenges faced by these countries in providing services in the modern world.

Key words
low-income countries; mental health; non-governmental organisations (NGOs); indigenous therapies

Introduction
In the world today there are enormous discrepancies in wealth, not just between individuals and families, but also between nations. In the post-colonial era when the cold war was in full swing, the term ‘third world’ was given to countries that did not fall into one or other power block. As economic development was seen as the way forward for all countries, the world was roughly divided into ‘developed’ and ‘under-developed’/developing’ nations. More recently the World Bank has introduced a classification that designates countries on the basis of gross national income per capita (www.worldbank.org/data/countryclass/countryclass.html). In this system, national economies are divided according to 2003 GNI per capita per annum, calculated using the World Bank Atlas method. Low income means $765 or less, lower middle income $766-$3,035, upper middle income $3,036-$9,385, and high income $9,386 or more. Examples of the various groupings based on income follow.

- Low-income countries include Pakistan, India, Nepal, Angola, Congo Republic, Tanzania, Kenya, Uzbekistan and Nicaragua.
- Lower-middle income countries include Albania, Russian Federation, Iraq, West Bank and Gaza (Palestine), South Africa, China, Sri Lanka, Turkey, Peru, Suriname and Brazil.
- Upper-middle income countries include Malaysia, Chile, Czech Republic, Saudi Arabia, Argentina, Mexico, St Vincent and Grenadines.
- High-income countries include Germany, Spain and other West European countries, Ireland, USA and Canada, Australia and New Zealand, Israel, United Arab Emirates, Qatar and Kuwait.

In line with some recent books dealing with mental health - for example, World Mental Health Casebook by Cohen and colleagues (2002) – this paper will use the distinction between lower-middle and upper-middle incomes as the dividing line between 'low-income countries' and 'high-income countries'.
Variation in mental health services

Interest in looking at cross-national differences in mental health services dates from WHO studies in the 1970s. These early studies were based on epidemiological approaches in that they looked for the 'incidence' of mental illnesses categorised according to DSM (American Psychiatric Association, 1994) or ICD (World Health Organisation, 1993). The assumption was that once 'incidences' of illnesses were known, treatments could be organised and implemented. But this is not how mental health services develop or improve in the real world, even if - and that is most unlikely anyway - incidences of categories of DSM or ICD-type illnesses provide an indication of the mental health needs of a society. One of the largest studies under the aegis of WHO was the International Pilot Study of Schizophrenia (IPSS) (World Health Organisation, 1973, 1979) which used the Present State Examination (Wing et al, 1974), devised in London (UK), to identify 'schizophrenia' - an approach severely criticised as being culturally insensitive in its approach (to say the least) and (at worst) imperialistic (Kleinman, 1977; Favazza, 1985; Fernando, 2002). In any case, these early studies are seen now as distinctly old-fashioned and of limited use for working towards meeting the mental health needs of culturally diverse populations where the very concepts of mental health, as well as the indigenous ways of coping with mental health problems, are variable.

Current scene

It is difficult to generalise across all low-income countries since (as in high-income countries) there is great variation in provision of services. However, services tend to fall into five types of provision: statutory (state) sector services that are usually free or nearly free at the point of delivery, services provided in the private (fee-paying) sector, therapy provided by indigenous healers such as Ayurvedic physicians, healing available at religious locations, and services provided by non-governmental organisations (NGOs). It would be correct to say that in all these countries general health and welfare services are under-developed and under-resourced. Hence, it is difficult to differentiate services directed at 'mental health' from those concerned with social care, welfare and physical ill-health.

Mental health systems in the state (statutory) sector are based largely on Western models of psychiatry and institutional care. Traditional asylums ('mental hospitals') dating from the colonial era still exist, often better staffed than they used to be, but still continuing old-fashioned approaches to care drawn from a hygienic era. Occasionally there are community programmes and/or rehabilitation services. In many countries there are psychiatrists in private practice, sometimes attached to private hospitals, but private treatment is expensive and not available to the vast majority of people. Many people in low-income countries seek and access indigenous systems of medicine for all sorts of problems including those seen (in Western terms) as those affecting 'mental health' or as 'mental illness'. For example, Ayurveda in South East Asia (Obeyesekere, 1997; Frawley, 1989), traditional Chinese medicine in China (Kaptchuk, 1983; Hammer, 1990) and a variety of systems in Africa (Prince, 1964; Ademunwagan et al, 1979; Last & Chavunduka, 1986; De Jong, 1987) are undoubtedly used by people who would, in Western terms, be deemed to suffer from mental health problems or mental illness. Since such problems are often seen in religious and/or spiritual terms, it is commonly the custom for people with such problems or illnesses to access religious healing systems, sometimes in conjunction with both indigenous and Western medical systems - see for example the case study of a mental patient in Sri Lanka described by Amarasingham (1980) and the studies in Sri Lanka by Wexler (1977, 1979). Not only is religious healing accessed by consulting private healers, but in many low-income countries there are temples, mosques, churches and other religious institutions that attract people seeking help and solace when suffering what in Western countries would be termed mental health problems or mental illness.

Finally, there are mental health projects developed by NGOs, many of which are financed by sources in high-income countries in Western Europe, North America and Japan. In many places, NGOs compete with one another, and so the services they provide are not co-ordinated. Some NGOs are controlled and directed indigenously by people in direct contact with local conditions and knowledgeable about local cultural norms and needs, but most NGOs are controlled and directed from outside the countries they serve. The latter tend to be geared to the interests and priorities of groups in donor countries,
rather than the needs of the receiving countries. Counteracting stigma, individual rights, institutionalisation or de-institutionalisation (Scull, 1977), GP-centred treatment, day-hospital-based group therapy and so on - usually whatever happens to be current dogma or fashion in the West - may determine the nature of the project pursued in low-income countries.

There are many books on 'development' that address issues in low-income countries. However, none refers to the development of mental health services in these countries except in passing, for example in some chapters in Development and Culture edited by Deborah Eade (2002). Many books and publications deal with community development (CD) (Jones, 1983) and participatory rural appraisal (PRA) (Chambers, 1983, 1997), but they do not address the application of these concepts in the field of mental health. The books that refer to mental health care in low-income countries - for example Psychiatry around the Globe by Julian Leff (1981), A Descent into African Psychiatry by Joop De Jong (1987) and Culture and Common Mental Disorders in Sub-Saharan Africa by Vikram Patel (1998) - seem to imply that mental health care should replicate systems pursued in Western, high-income settings. In other words, the message is that mental health care should consist of applying Western psychiatry across the globe. Until recently, the World Health Organisation (WHO) seemed to go along with this approach, for instance in pursuing the International Pilot Study of Schizophrenia (WHO, 1973, 1979) referred to earlier. Recently its stance has changed.


- continuity of care
- a wide range of services
- partnerships with patients and families
- involvement of the local community
- integration with primary health care.

In other words, the tendency is to move away from formal mental health services based on concepts of 'illness' (derived from Western models of psychiatry) as the basis of mental health care, towards a public health model. But WHO is not clear on this issue, perhaps reflecting the division of opinion generally on where exactly 'mental health care' as a category should fall and/or theoretical arguments currently prevalent about the nature of 'mental illness' itself when seen transculturally (Fernando, 2002). A recent paper from WHO (van Ommeren et al, 2005) points out that, if medical care is separated from psychosocial care,

mental health care services may inadvertently promote exclusively biological care for the severely mentally ill by drawing human resources skilled in non-biological interventions away from formal mental health services (2005 p71).

The view has grown that mental health systems must be home-grown as it were - they must be suited to the cultural context and needs of the communities themselves, and not based on models imposed from outside, developed in very different contexts and for very different purposes. That is not to say that all Western ideas, concepts and models of illness and health, etc should be rejected for use in non-Western settings - nearly all low-income countries tend to fall into being 'non-Western' culturally speaking - but that systems, whether of diagnosis or service provision, should be adapted and modelled to suit the context in which they are to be used, to suit the cultures and needs of low-income countries.

Recent publications
There have been some recent English language publications on mental health addressing the special needs and contexts of low-income - largely, non-Western - countries. World Mental Health, Problems and Priorities in Low-Income Countries by Desjarlais and colleagues (1995), World Mental Health Casebook. Social and Mental Programs in Low-Income Countries edited by Alex Cohen and colleagues (2002) and Meeting the Mental Health Needs of Developing Countries. NGO Innovations in India edited by V Patel and R Thara (2003) are the foremost among these. The first two books deal with general problems in providing appropriate mental health services in low-income countries, and
describe a few projects from China and Africa. The third contains descriptions of several mental health projects in
India, drawing upon the experience of workers in the
field. Two papers in the English language literature
reporting religious healing in South India (Raguram et al.,
2002; Haliburton, 2004) are also noteworthy.

Examples of innovative projects
in low-income countries
The Aro project in Nigeria was developed in the 1950s by
Dr Adeyo Lambo when he was Professor of Psychiatry at
the University of Ibadan (Lambo, 1965; Desjarlis et al.,
1995). This was essentially a village-based service in the
town of Abeokuta. Western therapeutic services were
grafted on to boarding out in four local villages of
patients, who were always accompanied by one or more
relatives. Western therapy and medical investigations (and
therapy) were combined with therapy from indigenous
healers, religious services and social activities.

A system of care incorporating Ayurveda was practised
for several years at a Buddhist temple at Nilammara just
outside Colombo (Obeyesekere, 1977). The Ayurvedic
tradition that developed at this centre for the treatment of
people with mental/psychological problems including
some people who were deemed ‘pissu’ (mad) was called
the Nilammara School. Here, too, clients who attended
the service were sometimes accommodated in a local village.
It is well known that there are numerous centres in Asian
and African countries where ‘mad’ people are taken for
cures – usually around some religious location, a temple,
mosque or church – although there are hardly any reports
on these services in medical or psychiatric journals.

A model of care developed in the 1950s in the urban
area of Shanghai has been called the Shanghai Model
(Chang et al., 2002). It started with establishing three-tier
levels of care (community, district hospital and municipal
hospital) for rehabilitation of ‘mental retardation’,
psychosis and epilepsy. Then innovations were added of
guardianship networks and home-based ‘sick beds’. The
Shanghai model is now composed of four items:

- guardianship networks
- community rehabilitation
- outpatient clinics attached to primary care facilities
- beds in district general hospital units.

A guardianship network is composed of local
helpers and volunteers who carry a limited ‘case load’ of
people (either ex-patients or people detected locally) and
‘look after’ clients in close association with families. Usually,
a network composed of three people – a family member, a
retired health worker and a community member/administrator – acts as a case-management team to assure
needed treatment, to intercede on behalf of the patient
and, if feasible, to integrate services for the patient. The
community rehabilitation centres comprise workshops
where ex-patients and people being looked after can be
occupied and perhaps paid a small wage. The outpatient
clinics are staffed by medically trained people (doctors).
The beds in the general hospital are staffed by mental
health professionals. Unique to China so far, community
models incorporating guardianship networks where they
exist have replaced commune and neighbourhood
committees (of an earlier era of collectivisation) as the
basis of mental health care (Desjarlis et al., 1995).

Ashagram is an indigenous NGO located in Western
Mahady Pradesh in India (Chatterjee et al., 2003). It had
started as a resettlement colony for recovering leprosy
patients. When this was successful, a colony for destitute
old people was started with government help. By 1996,
Ashagram had become a tertiary care centre for people
with a variety of disabilities. Then attention was given to
developing a ‘mental health unit’. Initially people
identified as ‘seriously mentally ill’ were targeted for
treatment as outpatients or inpatients. Building on the
credibility derived from helping these people, Ashagram
branched into developing networks to support and help
people with ‘mental and psychological problems’ by
involving local people such as sarpambdas (village
headmen), primary health care doctors and school
teachers, and later family members and volunteers.
Ashagram then graduated into developing ‘outreach
vans’ and ‘mental health workers’ drawn from
local communities in 72 villages, working with
Brainitis on identifying people who require mental
health care and providing it within the communities.

The main NGO in the field of mental health in Sri Lanka
is Nest (Fernando, 2002). It was launched in 1986 as a local
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initiative to rehabilitate women patients resident in a long-stay hospital. This led to the creating of a halfway house for ex-patients – the first Nest centre. In 1990, Nest launched a programme for training community health workers to reach out to people needing psychosocial support from its centres. Today, there are 24 community workers in eight centres scattered throughout the country, except in the Eastern and Northern regions that are affected by war. Each Nest centre (or house) has accommodation for two to four residents and two or three staff. Community workers based at the house then visit locally, helping people in need with both practical and emotional support. Second, they visit institutions such as remand homes and children’s homes, providing advice and sometimes using a Nest centre for respite. Finally, they work closely with professionals in the public health services, maternity services and primary care, providing advice and direct support for people with mental health problems. More recently, Nest has (as it were) taken the community into the hospital by opening an occupational therapy and rehabilitation centre within a long-stay women’s hospital, in an attempt to provide a pathway for the women eventually to leave hospital.

Conclusions
The challenge for middle- and low-income countries is to build mental health services based on principles and practices that both are consistent with indigenous traditions and worldviews and call on methods and experiences of value from both their own traditional sources and from Western ‘scientific’ knowledge and practice – and to do so in a context where resources are scarce, general medical services under-developed, poverty often endemic and social welfare minimal. And the services developed have to be ‘sustainable’ from the point of view of both cultural background and cost.

Limitations
First there are the economic and political restraints. Many low-income countries are beset with conflict and undergoing rapid social change. Corruption is endemic in many settings. Social welfare systems are often non-existent, so poverty reduction and mental health care are virtually inseparable. There is a shortage of professionally trained people (WHO, 2001b). Governments give mental health care a very low priority in the face of problems that are seen as much more urgent and pressing. Dependence on foreign aid – not least in funding NGOs — leads to a dependency culture that saps local initiative and drive, and renders resisting the propaganda of pharmaceutical companies very difficult.

The situation in low-income countries is that economic development and industrialisation (in whatever form they take place) need to be accompanied to a greater or lesser extent by rural development and poverty reduction - especially changing the lives of the vast majority of people who live in the countryside or small towns. Ideally, rural development should be based on aspects of community development (CD) or participatory rural appraisal (PRA) which depend on mobilising and supporting communities. It would seem that these approaches and/or ideas based on the educational approaches of Paolo Freire (1996), or spiritual and religious approaches arising from the cultural systems indigenous to the countries themselves, may be productive in planning and implementing mental health care in low-income countries, but there is little evidence that this actually happens on a significant scale.

Address for correspondence
Suman Fernando,
Honorary Senior Lecturer in Mental Health, The European Centre for the Study of Migration and Social Care, University of Kent, Canterbury, Kent CT2 7LZ, UK
Email: sumanfernando@btinternet.com

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