Public mental health – using the Mental Health Gap Action Program to put all hands to the pumps

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Although mental ill health constitutes a huge portion of the Global Burden of Disease (GBD), the majority of people with mental health problems do not receive any treatment, a scenario much worse in developing countries where mental health personnel are in gross short supply. The mhGAP was launched to address this gap, especially by training non-mental health professionals to deliver effective services for selected priority mental health problems. Especially in developing countries, many people with mental health problems consult traditional healers either as a first step in the pathway to biomedical mental health care or as the sole mental health service providers. Bridging the gap between mental health needs and available services in developing countries needs to incorporate traditional healers, who are ubiquitously available, easily accessible, and acceptable to the natives. Even though there are barriers in forging collaborations between traditional and biomedical mental health care providers, with mutual respect, understanding, and adapted training using the mhGAP intervention guide, it should be possible to get some traditional healers to understand the core principles of some priority mental health problems identification, treatment, and referral.

Keywords: pathway to care, religious and healers, biomedical medicine, collaboration, developing countries

BACKGROUND

Refinements in the tools and methodologies of psychiatric epidemiology have raised our understanding of the burden of mental disorders. More than a decade ago, the WHO reported that at any point in time no less than 10% of the population has mental disorders and at some point in their life 25% will develop mental disorders (1).

In a more recent report of the World Mental Health (WMH) Survey, it was reported that the prevalence of any WMH-CIDI/DSM-IV disorder in the prior year varied, from 4.3% in Shanghai to 26.4% in the United States. A good proportion of the 12-month cases were mild (between 33.1% in Colombia and 80.9% in Nigeria). The WMH authors concluded that serious (mental) disorders were associated with substantial role disability (2).

Moving away from the usual measure of only mortality, the collaboration between the WHO, World Bank, and Harvard University on the Global Burden of Disease (GBD) Project utilized the disability adjusted life year (DALY) – a summation of the years of life lost to premature mortality and years lost to disability (YLL + YLD). It was shown that neuropsychiatric conditions are responsible for 14% of the GBD, with unipolar depression ranking as the fourth most burdensome condition (3, 4).

Considering mortality, it has been estimated that one million suicides occur annually (5), with about 90% of the cases being associated with depression. According to WHO, this roughly translates to one suicide death every 40 s. Suicide ranks among the three leading causes of mortality among 15–45 years olds (for both genders). There is also reduced life expectancy in persons with schizophrenia, learning disabilities, dementia, bipolar disorders, and other major mental disorders.

In 2007, the Lancet published a series on global mental health (6). These series, \textit{inter alia}, contain three core observations:

1. Mental disorders represent a substantial “though largely hidden” proportion of the world’s overall disease burden.
2. Every year up to 30% of the global population will develop some sort of mental disorder.
3. There is strong evidence for scaling up mental health services worldwide.

To what extent are these burdens being addressed by the present system of health care delivery? According to the WMH Survey, the majority of those who need mental health care globally do not receive any treatment. In developed and developing countries, respectively, 35.5–50.3 and 76.3–85.4% of people with mental disorders had not received any form of treatment in the previous 12 months (2).

Low and middle income countries (LAMIC) have very low levels of personnel and resources for mental health services. For example, the WHO Mental Health Atlas reports the following staff to population ratios per 100,000 populations for Nigeria: 0.06 psychiatrists, 0.02 psychologists, 0.19 nurses, 0.09 non-specialized doctors (7). Especially in LAMIC, mental health resources are also unevenly spread between urban/rural and north/south locations, etc.

Thus there are huge gaps between needs and available services both within and between countries.
The Mental Health Gap Action Program (mhGAP) was officially launched by the WHO to address this gap in treatment for individuals with mental, neurological, and substance use disorders (8). One of the principal keys to success in the mhGAP program is partnerships. The WHO maintains that countries are to make the decisions as to how best to deliver the mhGAP intervention packages at health facility, community, and household levels to ensure high quality and equitable coverage. In other words, the major task is to identify the people who will be responsible for the delivery of the mhGAP interventions at each level of service delivery. To identify those who will deliver the mhGAP services at any level, it is necessary to know where to locate those who have mental, neurological, and substance disorders.

**WHO OFFERS MENTAL HEALTH SERVICES ACROSS THE WORLD?**

All over the world, people living with mental, neurological, and substance disorders, when they do seek treatment, do so in a wide variety of sources, both formal and informal.

In describing the pathways to mental health care in eight countries in Eastern Europe, Gater et al. (9) reported that between 6 and 10% of the participants with mental disorders had consulted either religious or traditional healers before accessing psychiatric services. Despite the availability of biomedical practitioners and the socially subsidized medical care in Norway, some patients with mental disorders, especially the Sami populations still patronize traditional healers (10, 11).

A number of factors, including economic, demographic, social, cultural, psychological, clinical; have been associated with help seeking and care received by patients with mental disorders (12).

Studies in high income countries indicate that general practitioners and mental health professionals are central in pathways to psychiatric care whereas in Africa general duty doctors play a less important role. (27–33). In one study of mental health service use in South Africa, incorporated in the WHM Survey, concluded that alternative practitioners, including traditional and faith leaders, play an important role in the delivery of mental health care in South Africa. They reported that 13% of the participants made use of traditional healers to a tertiary psychiatric service in Nigeria, Acha and Odejide (21) reported that traditional and religious healers were consulted at some stage, mostly first contact, by many of the patients. Noting that patients who consulted traditional healers were more likely to arrive at a tertiary psychiatric service much later than those who consult other carers, the authors suggested that attempts to incorporate traditional medical care into the health care system must seek to improve their referral skill. It would seem that this suggestion jumps the gun. The traditional healers in that study had not been given any form of training in identifying and treating mental disorders before the issue of referral would become relevant.

Crawford and Lipsedge (22) reported that Zulu people in South Africa found western medicine useful for treating physical illness, but not mental illness principally because many mental health problems are considered to be understood only by traditional healers from their own culture. Africans in general are a very cultural and religious people who have great trust and confidence in their traditional and faith leaders.

In a study of help seeking by patients with a major depressive disorder in a South African Community, Andersson et al. (23) reported that 13% of the participants made use of traditional healers and were satisfied with the services. Sorsdahl et al. (24) in a study of mental health service use in South Africa, incorporated in the WHM Survey, concluded that alternative practitioners, including traditional healers and religious advisors, play an important role in the delivery of mental health care in South Africa. They found that 9% of the patients with mental disorders had used native healers and 11% had consulted faith healers.

Studies from Arab countries have also shown that the majority of patients with mental disorders consult traditional healers (faith healers, diviners, and herbalists) before seeking any biomedical doctor’s help or western treatment (25, 26). Similarly, in Asian countries patients with mental disorders first consult native healers while general practitioners play a less important role. (27–33). In one Chinese study, Zhang et al. (34) reported that only 5.5% of their patients with mental disorders first made contact with mental health service. In one study in Central India, Lahariya et al. (35) reported that 68.5% of patients with mental disorders first consulted faith healers.

It seems evident that mental health services are offered in a variety of settings by different groups, individuals, organizations, and health systems across the world. In many countries of the world, traditional and faith healers are the front line providers of mental disorders who sought help at a local Psychiatric hospital, nearly half (48%) had first sought healing for mental health issues from religious leaders, primarily through prayers.

Of 238 patients who attended a mental health service in Ilorin, Nigeria, during a 1-month period, Abiodun (20) reported 40% had first contacted traditional or religious healers. The author suggests that use of psychiatric care in developing countries could be improved by training primary health care workers to give mental health education to the communities they serve. This suggestion seems out of tune with the findings of the study; traditional and faith healers are not formal primary health care workers. When patients develop mental disorders, they first visit traditional and faith healers, not formal primary care health workers.

In one study of the pathways of 159 patients with mental disorders to a tertiary psychiatric service in Nigeria, Acha and Odejide (21) reported that traditional and religious healers were consulted at some stage, mostly first contact, by many of the patients. Noting that patients who consulted traditional healers were more likely to arrive at a tertiary psychiatric service much later than those who consult other carers, the authors suggested that attempts to incorporate traditional medical care into the health care system must seek to improve their referral skill. It would seem that this suggestion jumps the gun. The traditional healers in that study had not been given any form of training in identifying and treating mental disorders before the issue of referral would become relevant.

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(initial) mental health services. They can only be ignored at the peril of patients who need mental health services. Can traditional and faith healers be trained in the mhGAP intervention?

**USING TRADITIONAL HEALERS TO OFFER mhGAP**

Some countries have contextualized the WHO mhGAP Intervention Guide. The WHO and World Organization of Family Doctors (WONCA) have argued that integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need (36). This stand presupposes that most people with mental disorders attend primary care and may be detected at that level. However, this is far from reality. In many developing countries as we have seen above, the majority of people with mental health problems use the services of faith and traditional healers, either alone or a step in the pathway to consulting experts in mental health. Therefore any program that would bridge the gap between mental health needs and services must take faith and traditional healing into account in developing countries.

Involvement of faith and traditional healers in orthodox medical care is a very complex issue. Patel (37) has argued that “the greatest obstacle to a collaboration has been the mutual suspicion between the two sectors and the concerns of the biomedical sector and the religious establishment regarding the ‘unscientific’ and unorthodox practices of traditional healers.” A major barrier in any such collaboration, according to Patel (37) includes the fact that there is a great diversity of traditional healers and moreover, there is lack of agreement on what constitutes evidence to guide policy and practice when the epistemologies of traditional medicine differ so vastly from that of biomedicine.

Although it is argued that some traditional healers do harm, orthodox western medical practitioners also do harm in various ways. The inescapable reality, Patel argues, is that traditional healers are far more numerous than biomedical providers and they play a particularly important role for mental health care. He concludes that an innovative system, guided by evidence and common sense, needs to be worked out where the collaboration between native healers and western orthodox medical practitioners will lead to complimentary rather than competitive therapy approaches.

According to Leavey and King (38), even though many clergy already provide pastoral care for emotionally distressed people, they may be reluctant to move further away from spiritual guidance – their “core business” – toward a more secular enterprise. They observed that the great heterogeneity of beliefs about suffering and healing among mainstream organizations, has particular resonance in relation to certain Evangelical and Pentecostal churches, which maintain deeply held beliefs and practices surrounding demonic possession, healing, and deliverance rituals. It is a great challenge for mental health professionals to engage with clergy who believe that sin or demonic possession lies at the root of a person’s illness. Leavey and King (38) conclude that it seems unlikely for clinical and legal reasons that services could or should collude with religious healing.

Robertson (39) argues that desirable as collaboration between western medical and traditional healers may be in Africa, there is a need to have expanded detailed studies of the knowledge, methods of practice of traditional healers, and how best to work out any collaboration.

In a qualitative study of traditional mental health care in Ghana, Ae-Ngibise et al. (40) observed that there are many reasons for the appeal of traditional and faith healers, including cultural perceptions of mental disorders, the psychosocial support afforded by such healers, as well as their availability, accessibility, and affordability. According to the authors, there are enormous barriers hindering collaboration between orthodox and traditional healers, including human rights and safety concerns, skepticism around the effectiveness of “conventional” treatments, traditional healer solidarity, and paradigmatic disjunctions and widespread skepticism between different treatment modalities. However, mutual respect and bi-directional conversations were the key ingredients for successful partnerships espoused by traditional healers in that study; therefore, promoting greater understanding, rather than maintaining indifferent distances may lead to more successful co-operation.

In a qualitative study of biomedical and traditional health practitioners in Cameroon, Wamba and Groleau (41) reported that biomedical practitioners and priests expressed reluctance in building reciprocal relationships with traditional healers and prophets. In a study of traditional and biomedical mental health practitioners in Tonga, Vaka et al. (42) reported that traditional healers had a negative view of the western-style system.

Some traditional healers lay claim to having cure for many diseases such as diabetes, hypertension retroviral disease, and epilepsy (43).

It is our contention that biomedical practitioners seem to put themselves on too high a pedestal. There is an eternal tendency for disdain against alternative medical practitioners. Yet we cannot wish away the fact that traditional healers have come to stay and are rendering unquantifiable mental health service. Until we have a total replacement alternative, we must have a way to accommodate traditional healers in the mental health service system in developing countries.

The claim of superiority over biomedical practitioners by some traditional healers creates the scenario of a supremacy battle.

Yet, strong and apparently reasonable as the arguments about the difficulty of collaboration may appear, it would seem that these difficulties have been unduly exaggerated. In reality, human nature is more universal than different, and suffering, distress, and how to remove them is a common thread across all people, wherever and however they are achieved. We are basically similar as human beings and the ultimate goal of every being is self actualizing. In whatever situation we look into, the basic principles of human relations are universal: empathic understanding, unconditional positive regard, and genuineness. It is not in doubt that many traditional and faith healers are bountifully imbued with these qualities. What needs to be done is to create a spirit of mutual understanding, respect, and co-operation.

The African Regional Strategy on promoting the role of traditional medicine in health systems strives to promote and encourage the collaboration between practitioners of traditional and conventional medicine (44, 45).

In a review of the participation of traditional healers in HIV/AIDS care in Africa, King and Homisy (46) reported...
encouraging results when these traditionalists are given some form of training and remain supported. Collaboration and partnerships between traditional and biomedical health professionals in HIV/AIDS care have been promising in many African countries including Botswana, Central African Republic, Guinea, Malawi, Mozambique, Tanzania, and Zambia (47). It has been amply shown that traditional health practitioners can be used to scale up HIV/AIDS care (48–51). Reports from Kenya, Mali, Senegal, South Africa, Uganda, and Zambia indicate that biomedical and traditional health practitioners can positively and successfully collaborate in the care of HIV/AIDS (45, 52).

The lessons already learned from HIV/AIDS collaboration could be extrapolated to mental disorders. In an East London project exploring traditional and faith based mental health healing by practitioners of African and Afro-Caribbean descent, it was found that adequate engagement could lead to a good collaboration with genuine faith healers accepting the treatment guide provided by biomedical healers (53). The project, Partnerships for Mental Health Development in Sub-Saharan Africa (PaM-D) (54), a hub aimed at creating an infrastructure to develop mental health research capacity in Sub-Saharan Africa works to integrate biomedical psychiatric care with traditional practice. With training and mutual respectful collaboration, the capacity of traditional healers to identify mental disorders and provide support, and referral to biomedical practitioners can be enhanced (2, 48, 55, 56).

The present WHO mhGAP is an opportunity to bring traditional and faith healers on board of the mental health service system in developing countries. With adapted training using the mhGAP intervention guide, it should be possible to get some traditional/faitheal healers to understand the core principles of some priority mental health problems identification, treatment, and referral. This is one sure way of bridging the treatment gap and closing the inequity and inequality chasm in mental health care.

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**Uwakwe and Otakpor Using traditional care in mhGAP**

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Collaboration with Traditional Healers in HIV/AIDS Prevention and Care

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