

## **Mental health and poverty reduction**

### **Report of the Burundi conference organized by HealthNet TPO and the Ministry of Public Health**

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#### **Introduction**

The Great Lakes Regional Conference on Mental Health and Psychosocial Interventions occurred in Burundi on the 24<sup>th</sup> and 25<sup>th</sup> of January, 2008 by the Ministry of Public Health in Burundi and HealthNet TPO Burundi. This was a follow up to a conference held on 'Integration of Mental Health into Primary Health Care' that had occurred in 2006. The overall objective of the conference was to promote regional sharing of experiences by various stakeholders, including: governments, nongovernmental organisations, UN agencies, and others active in the field of mental health. Representatives were invited from Uganda, Southern Sudan, Tanzania, Rwanda and the Democratic Republic of Congo. The conference also included excellent representation from the Burundian Ministry of Public Health and Prevention of HIV-AIDS.

#### **Summary of the proceedings**

**Dr Gary Belkin** provided an explanation of the mental health component of the Millennium Villages Project (MVP). The MVP is a joint initiative of the Earth Institute at Columbia University and the United Nations Development Programme (UNDP). (See [www.millenniumvillages.org](http://www.millenniumvillages.org)). Mental health is emerging as an important determinant of 'social capital' as well as something that is influenced by it. This means that mental illness interferes with functionality and the adequate role fulfilment that is needed for economic participation and social success. There is a link, therefore, between mental health and poverty. He also highlighted that there are cost-effective interventions for mental illness. The logical next step is to demonstrate that adding a mental health component to a developmental intervention package will lead to a better outcome. One important component of the mental health intervention package is to include in it the training of primary health care workers in the recognition and management of mental illness, including village health worker training. Core skills that need to be installed in community health workers include: psycho education; case identification and referral; provision of interpersonal support; problem solving; and ways to improve compliance of treatment. The MVP hopes to document the process for doing this so that replication and scale up for other areas, and within country programmes, can occur more efficiently.

**Mr Willem van de Put**, the Director General of HealthNet TPO made a presentation on mental health and psychosocial support as essential elements of all development work. HealthNet TPO not only works in the area of mental health and psychosocial issues, but also in the financing of health systems and disease control. This work is carried out across many conflict affected countries around the world. Modern warfare tends to focus on the destruction

of social networks and community structures. At the bottom of this, is the underlying poverty that eats away at the social fabric. The focus or inclusion of mental health and psychosocial interventions in programming for conflict affected populations contributes to the rebuilding of social networks through the rebuilding of the individual, as well as of the community. Mr van de Put concluded by stating that the inclusion of mental health into development programs should not have to be defended any more, it should now be sufficiently clear to all. Rather, it is more the need of the providers of services, whether NGOs or government sectors, to prove themselves to the people for whom the interventions are developed.

**Dr Shekhar Saxena** of WHO (Geneva) presented work from the Department of Mental Health and Substance Abuse of WHO. He provided an overview of the global disease burden for neuropsychiatric disorders, and the World Health Report recommendations for 2001, that are still valid. The WHO has carried out studies trying to establish the ability of country mental health systems to respond to these needs. Findings indicate that there is a gap in all countries, both rich and poor, between the burden and the budget allocated to mental health. However, low-income countries have a much longer way to go in getting their budget up to at least 1% of the health budgets. In most countries, there is still an excess of beds in large institutions rather than in the community, and resources for mental health are scarce. Therefore, it is inequitably distributed and inefficiently utilised. The WHO argues that the scaling-up of a package of selected mental health interventions is possible<sup>1,2</sup>. The organization has developed several initiatives, such as the Mental Health Global Action Programme (MHGAP). This programme's objectives are to increase the commitment of governments and international organizations to achieve higher coverage of mental health programmes with key mental health interventions in resource poor countries. Importantly, is an integrative approach that recommends developing a package of essential mental health interventions that can be delivered by the primary health care worker at the same time as other health services are provided. This is more cost effective in terms of training, implementation and supervision. Another initiative created by the WHO and supported by DfID is the Mental Health and Poverty Project (MHaPP) that is currently being implemented in four African countries (Ghana, South Africa, Uganda and Zambia). The overall objective of this consortium is to generate new knowledge regarding comprehensive multisectoral approaches to breaking the negative cycle of poverty and mental ill-health.

**Dr Edwige Faydi** provided an overview of the project that she is involved with, on the development of national policies for mental health. This project is assessing service organisations. In particular, the project attempts to define the optimal mix of services on different levels versus the needs of the beneficiaries of those services. Some of the recommendations to optimise resources that were made were: to limit the numbers of hospitals, to build a community mental health services, to integrate mental health into primary health care and develop intra and inter sectoral collaboration.

Both Dr Saxena and Dr Faydi provided information on various documents that have been produced by WHO in the past few years and are available on the WHO website ([www.who.int](http://www.who.int)). These can also be ordered by sending an e-mail through the website.

**Dr Pierre-Claver Bazombanza**, the Director General of the Ministry of Public Health and Prevention of HIV-AIDS (MPHPH) of Burundi made a presentation on the mental health system of Burundi. The mission of the

mental health department in the Ministry is to develop, implement and evaluate the program, promote research, organise services for the vulnerable, set up community mental health services and prevent mental illness. During the first conference in 2006, the Burundian authorities had almost nothing to present, but at this conference they were able to demonstrate that a mental health strategy has been written and approved, and training modules for integrating mental health into primary care have been written, as well as trainers have received training.

**Mr Herman Ndayisaba**, the Country Director of HealthNet TPO in Burundi and **Dr Peter Ventevogel**, Mental Health Advisor of HealthNet TPO, provided an overview of the programme including: its inception in 2000; the scaling up; and the current process of handing over the services to the Ministry of National Solidarity and MPPH. The focus of HealthNet TPO in Burundi operates at two different levels; the integration of mental health into the primary health care services and psychosocial interventions at both the group and community levels. The presentation of HealthNet TPO Burundi mentioned that an important lesson they had learned was that making services sustainable is a long process. To do this well it is important to nurture policy support from the government through supporting them to anchor mental health and psychosocial care in the national policies. According to their experience, there is a better probability of achieving sustainability by working with community structures, such as local groups or associations, than by training individuals.

Following this session, there were country presentations from: **Tanzania (Dr Joseph Mbatia); Rwanda (Dr Naason Munyandamutsa); the Democratic Republic of the Congo (Dr Muteba Mushidi); and Uganda (Dr Sheila Ndyanabangi)**. These presentations made it clear how different various countries are in respect to development of mental health care services. All of the countries mentioned are integrating mental health into primary health care and have developed national mental health strategies. Rwanda stands apart from the rest as the impact of genocide still determines a large part of the burden of mental illness and the programming of interventions. Current levels of specialised mental health personnel vary from country to country as well. The Democratic Republic of Congo has 25 psychiatrists and over 100 psychologists in the country, but almost all of them are based in the capital Kinshasa. On the other hand, Uganda has a good collaboration with NGOs providing support for people with mental illness, and through this collaboration, is able to provide livelihood schemes to this group. Challenges to improve services to those presenting with mental illness include the large number of patients that are still using traditional healers and the problem of how to identify common mental illnesses.

**Mr Hicuburundi**, the Director for Planning in the Ministry of Public Health in Burundi presented the Burundi Poverty Reduction Strategy. The aim of this document is to increase the purchasing power of the population, as well as increasing access to social services. The principles included are the country ownership of the process, as well as wide consultation and participation of the population. Current challenges to poverty eradication include: poor governance, especially in the rural areas; ongoing conflicts; macro-economic instability; gender inequality; and the large numbers of orphans and other vulnerable children resulting from the conflicts. The strategy has four main pillars, but the two that relate to health and mental health in particular are Axis 3 on development of human capital, and Axis 4 that focuses on fighting HIV/AIDS.

The presentations that followed were research oriented. **Dr Ventevogel** presented the cost effectiveness study of mental health interventions in Burundi that had been carried out under the direction of Dr Joop de Jong. The study demonstrated a clear cost effectiveness of the interventions highlighted: the mean cost per month of individual counselling is around 2 (US) dollars, while the gain by the patient is around 13 USD (measured in increased productivity and decreased spending on other services). **Mr Mark Jordans** presented the Child Thematic Project of HealthNet TPO that highlighted a scarcity of evidence based mental health and/or psychosocial interventions for conflict affected children. There is also a need to show that study context interventions can be translated into programmes. He outlined the process taken in developing a delivery framework; a comprehensive care package is developed, then a toolkit that shows the process for implementation is developed, and then the evidence is collected on whether it works or not. He outlined some of the interventions, especially in the areas of community based interventions and the secondary level interventions of the Classroom Based Psychosocial Interventions (CBI). Some of the research outputs for this study are evidence of the efficacy of the CBI; the impact of war on children, validation of the screening instrument, single case studies and literature review. The CBI showed a moderate effect size. **Dr Femke Verduin** made a presentation on the evaluation of socio therapy in Rwanda. Socio therapy is a group approach, which has its basis in social capital theories (mentioned above). The focus of the approach is on each individual in the group gaining trust of the others. The results seemed to indicate that socio therapy leads to a significant effect in building trust in others, and in better psychosocial well being, but also showed a negative outcome for social capital. This will have to be investigated further.

**Dr Kigozi**, from Uganda, made a presentation on sustainable mental health systems using the case example of his own country. He emphasized the need to balance community versus hospital based mental health care in a setting of limited resources, and to institutionalize the integration of mental health in a guided manner at all levels of care.

**Dr Margaret Hogan** (on behalf of Dr Sylvia Kaaya) presented results from a study on HIV/AIDS, mental health and pregnancy, with a focus on depression. This was a nested study, where a larger study on the impact of vitamin supplementation on the progression of HIV/AIDS among pregnant women was being carried out, and the study on HIV/AIDS, mental health and pregnancy was carried out on some of the larger study subjects. Two key findings were that depression is associated with an increased risk for HIV/AIDS disease progression, and ante natal depression and perceived low social support are predictors of post natal depression. Being married was moderately associated with post natal depression, married women had a slightly more likelihood to have symptoms of post-natal depression.

**Dr Florence Baingana** made a presentation that outlined possible sources of financing for mental health programmes, for governmental programmes, NGO sector programmes, and for individuals who work in the field of mental health. Mental health and psychosocial funds can come in many forms; it may fall under social action or social protection programmes, or it can be under health projects, or even as education projects. Some funds can be linked to specific issues, such as HIV/AIDS, as Dr Kaaya very ably demonstrated, or conflicts, as most of the work presented in the conference demonstrated. Dr Baingana provided a short list of some of the funding opportunities that are presently available, and encouraged participants to search on the various websites. Some of the important things to keep in mind included: having a

strategic plan that includes a fund raising component, designation of someone to take on the role of coordinating the fund raising activities, taking into account the sources of funds, the mandate of the funding agency, the funding cycles, and the opening and closing dates of funding announcements. It is also important to network as much as possible, as well as collaborate.

A group discussion followed with four themes: 'the role of mental health and psychosocial interventions in the political development of the countries in the Great Lakes Region'; 'the integration of mental health and psychosocial interventions in existing systems of the Great Lakes Region'; 'how to strengthen regional and international cooperation in the area of mental health and psychosocial interventions'; and 'elements of a financing strategy for the mental health sector'.

**Recommendations** from the group activities are listed below.

1. To target improved social cohesion and develop policies that organize collective and individual support, in order to reduce the generalized traumatic effects of violence in the region.
2. To focus more attention on the prevention of gender based violence.
3. To view mental health promotion as a public health priority; to be included in the national mental health programmes in each country, as well as allocating a sufficient budget to it.
4. To promote community sensitization on mental health issues and sufferers.
5. To develop a phased system of training health workers in mental health on different levels of the health care system.
6. To promote a multi-sectoral view of mental health, not as the unique business of the Ministry of Health, by redefining the curricula of training at primary, secondary and tertiary levels (Institutes and Universities) in the Ministry Education, and to collaborate with other Ministries.
7. To improve availability as well as subsidize the costs of psychotropic and epileptic medicines at all levels.
8. To include mental health components in health financing reforms such as performance based financing.

The **Minister of Public Health and Prevention of HIV/AIDS** closed the conference by restating the importance of mental health and psychosocial interventions in poverty alleviation.

#### **Reflections of the author**

The points listed below are some of the issues that the author took away from the conference.

1. This conference had a combination of high science as well as down-to-earth programme activity presentations. The excellent mix of participants, especially those from the countries in the Great Lakes Regions, provided a good opportunity for networking. By the end of the conference, many of the participants had made plans to invite southern partners to their countries to continue some of the dialogue began here.
2. One of the disappointments was the undertone of the weakness of hard evidence concerning the psychosocial interventions. During the meeting, we heard that CBI has modest effects, socio therapy also had modest and sometimes contradictory impacts, and counselling

alone was not effective, for example, in relation to depression and HIV. There is other work carried out that showed small or no effects, such as the study of Paul Bolton and others, on play therapy and interpersonal therapy for adolescents in war affected Uganda<sup>3</sup>. In southern Africa, REPSSI, the Regional Psychosocial Support Initiative, even had to stop an evaluation study when results consistently seemed to indicate no, or limited, effectiveness. These results could easily discourage. However, there may be methodological problems such as the choice of the outcome indicators, so further work has to be done. It may become clear that certain interventions are not effective. In such cases new interventions should be developed that take into account lessons learnt from these studies. If these interventions are not effective, they should no longer be recommended for large programme interventions.

3. It was heartening to hear that some of the participants felt that we do not have to defend mental health. However, some of the participants, especially in the groups, still believe that mental health is a charity issue and advocate that services should be provided free of charge, or at reduced cost. I disagree. We have often seen that when services are provided free of charge, the quality inevitably declines. The charity case argument also reinforces the stigma attached to mental illness.
4. The need to have clear indicators for psychosocial interventions still exists. The area of psychosocial interventions will continue to flounder until clear indicators are developed. This goes hand in hand with being able to demonstrate strong effectiveness for these interventions. 'Psychosocial' must move out of the realm of *hocus pocus* into the central stage of evidence based science.
5. Mental health coordinators did not seem to mention psychosocial, or to integrate components of these interventions, in their strategies. The divide between mental health and psychosocial still continues, and as long as the two are unable to meet and collaborate, especially in the design and delivery of programmes, then the populations they serve will continue to get a disintegrated and inefficient service.

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