BUILDING BACK BETTER – SUSTAINABLE MENTAL HEALTH CARE AFTER EMERGENCIES: SUMMARY OF A WHO REPORT

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During the emergencies, mental health requires special consideration as there are increased rate of mental health problems, weakened mental health infrastructure and difficulties in coordinating agencies that are providing mental health relief services. While the challenges related to mental health care are considerable, emergencies also present unique opportunities for better care of all people with mental health needs.

Emergencies, in spite of their tragic nature and adverse effects on mental health, are unparalleled opportunities to build better mental health systems for all people in needs. This is important because mental health is crucial to the overall wellbeing, functioning, and resilience of individuals, societies and countries recovering from emergencies.

This report aims to ensure that countries faced with emergencies will not miss the chance to use available political will for change and to initiate mental health reform. Case Studies from 10 different countries demonstrate it is possible to bring about systematic change in ensuring sustainable mental health care even after emergencies.

CASE STUDIES FROM 10 COUNTRIES

Afghanistan: The country experienced violence and instability for the past 30 years and the surveys indicate that after the fall of the Taliban government in 2001, there was high level of mental distress in the Afghan population. Mental health services in Afghanistan had been limited and strongly hospital based and people from mental disorders sought help from traditional healers in their communities. Situation changed, after 2001 as the new government contracted NGOs for providing health services and Ministry of Public Health concentrated on regulation and policy making which strengthened mental health care. However, there are still challenges that are in need to be resolved as mental health issues require more attention in health workers' pre-service educational curricula.

Burundi: Prolonged warfare and conflict led to a range of social and mental health problems in Burundi. Modern mental health services were almost non-existent prior to the past decade and until 2000, the Ministry of Public Health did not have a mental health unit nor mental health policy and plan. The mental health programmes were initiated by a NGO named Transcultural Psychosocial Organization at the request of Burundians was able to provide mental health assistance to 17713 people. From 2006-2008, the mental health clinics in the provincial hospital registered almost 10000 people and in 2011 funding from the Dutch government led to inception of a 5 year project which aimed to strengthen health systems. This transition of service from 2007 to 2010 also had challenges as the government faced severe funding problems, political instability which hampered its decision-making.

Indonesia (Aceh): Indonesia suffered from more than 30 years of conflict between the Free Aceh movement and the Indonesian military. Moreover, it was also hit by worst tsunami in 2004 recorded in human history which increased the demand of mental health and psychosocial support services. As a support, Ministry of Health and WHO provided

leadership to develop sustainable community based mental health services whose actions were based on WHO's (2005) Recommendations for Mental Health in Aceh. In 2011, 13 out of 23 districts/municipalities had specific mental health budget which indicating progress in coverage of mental health services.

Iraq: In terms of Iraq, there were many changes in mental health service from 2003 to 2011. Baghdad mental health hospitals were reformed and 25 new mental health units offering mix of inpatient and outpatient services were established. By the end of 2011, there was integration of mental services within Primary Health Care (PHC) services and 34 new outpatient-only units were established. However, the challenges faced by Iraq were lack of financial support for mental health, violence and lack of security in many parts of the country. The Government of Japan, the European Commission, and the World Bank have stepped forward to support Iraq. Iraqi government has also started to allocate more of its own budget for mental health programmes.

Jordan: The flow of displaced, war affected Iraqis into Jordan drew funds from many agencies for mental health support. The health ministry and WHO also initiated a pilot project to provide community-based mental health care which was an achievement for change. A first ever mental health policy was also developed and new mental health units were also established within the ministry of health to lead the governance within the mental health sector. However, there was initial reluctance among a number of mental health specialists with government's programmes and priorities for mental health reform.

Kosovo: In 1990s, the overall health system of Kosovo suffered from neglect and lack of funding and the situation got worsened with the 1999 war. The crisis in 1999 opened the gateway for mental health reform which resulted in availability of mental health services into seven regions within Kosovo. A range of mental health services was also developed to provide continuous care for people with mental health needs: one community based mental health center, one patient ward in a general hospital and one residential facility for mental health patients.

Somalia: Due to ongoing crisis and weak governance structures, full reform of the mental health system has not been possible. The Chain-Free Initiative developed by the WHO in 2006 was able to remove the invisible chains of societal stigma and human rights restrictions among the people with mental disorder. Health workers training also built the capacity of 55 health workers from the three zones of Somalia. Mental health situation analysis raised awareness among national and local partners and helped attract the attention of donors. However, the challenges still exist in terms of lack of an effective central governance structure, lack of funds and infrastructure directed to mental health which needs to be revised and taken into consideration.

Sri Lanka: The tsunami of 2004 was the worst natural disaster in Sri Lanka that recognized the need to address the acute psychological distress of survivors. For addressing the needs of the survivors, the new policy was effective from 2005 to 2015 which emphasized comprehensive, decentralized, and community based care. The expansion of mental health services in Sri Lanka was observed to be growing from 2004 to 2012 due to various funded development project and community empowerment. Though the government has not funded the CSO cadre, and although the diploma course in psychiatry has led to resistance, Sri Lanka has been able to identify and implement innovative solutions to the shortage of mental health workers in tsunami affected areas and in country.

Timor-Leste: Prior to the humanitarian emergency of 1999, there were no mental health professionals or mental health specialist service in the country. In 2000, a consortium of Australian agencies led by the Psychiatry Research and Teaching Unit began developing the first ever mental health agency in the country named Psychosocial Recovery and Development in East Timor (PRADET). PRADET initially trained 16 Timorese health workers and continued to

play a prominent role in mental health and psychosocial support. However, the programme also faced challenges from the outset in terms of sustainability and transitioning to a longer-term development phase for mental health service.

West Bank and Gaza Strip: Following the start of the second intifada in 2000, renewed international attention and donor support were focused on mental health in the West Bank and Gaza Strip. Though, reform has affected mental health care at primary, secondary and tertiary levels, good progress has been made towards establishing a number of mental health centers in both West Bank and Gaza strip. However, the occupation and intermittent conflict are ongoing followed by economic hardships, repeated violence and the human rights violations. Within this context, mental health services have still continued to struggle with physical and political separation between the West Bank and Gaza Strip.

MAJOR OBSERVATIONS FROM CASE STUDIES

The major observations from these case studies are enlisted below:

1. Mental health reform was supported through **planning for long term sustainability** from the outset.
2. The broad **mental health needs of the emergency affected population** were addressed.
3. The **government's central role** was recognized.
4. **National professionals** played a key role.
5. **Coordination across agencies** was crucial.
6. Mental health reform involved **review and revision of national policies and plans**.
7. The **mental health system** was considered and strengthened as a whole.
8. **Health workers** were reorganized and trained.
9. Demonstrated **projects offered proof of concept** and attracted further support and funds for mental health reform.
10. **Advocacy** helped maintained momentum for change.

CONCLUSION

This report shows that mental health reform is realistic as a part of recovery, even in highly challenging circumstances. The above enlisted observations are the key indicators in achieving success of the mental health reform and that the program planner should seize the opportunity to use emergencies as a catalyst for mental health reform. It also urges the need of the mental health reform as it has been neglected far too long and is crucial not only to people's wellbeing, but also to the functioning and resilience of societies recovering from emergencies.

REFERENCE

Building Back Better: Sustainable Mental Health Care after Emergencies, WHO, 2013