CLINICAL PERSPECTIVES:

Interview with Minister Leslie Ramsammy:

Mental Health in Resource Poor Settings: A Social Justice Model

Interviewers: Dr. Normand Carrey, Dr. Sonia Chehil

The Honorable Minister of Health from Guyana, Dr. Leslie Ramsammy, is the current President of the World Health Organization's 61st World Health Assembly and the President of the Pan American Health Organization 47th Directing Council (2006-2008). In Guyana he has been a Member of Parliament since 1997, and is the longest standing health minister in the world. He is the current Chair of the Steering Committee for the establishment of the Caribbean Public Health Agency, a current director of the Global Fund Board representing Latin America and the Caribbean, and a Member of the Policy and Strategy Committee of the Global Fund representing Latin America and the Caribbean.

The interview took place on November 23, 2008 in Halifax, Nova Scotia.

Welcome to Canada, Minister. You are brave to visit us in the winter time.

1) *You point out that in the model you are proposing that partnerships between institutions are important; how do you accomplish this in an era of shrinking health care budgets?*

This alternative model is important for many reasons-it has demonstrated a low cost way of pursuing partnerships. In previous models we had scholarships for a single person to go to developed countries to learn very esoteric skills and hope that they would come back.

There are many reasons why this old model is ineffective–first of all, it is expensive to send one person out (currency exchange, etc.), and there is no capacity building at the local level since the expertise is not present. In addition, as I have alluded to above, what happens if that person is enticed to remain in the country where he or she was receiving training as often happens? Poof, your investment goes down the drain.

In this current model, and this is possible because of advanced web based technologies, personnel are trained locally by distance technology from developed countries. We have the triple advantage of increasing local expertise, increasing capacity at home and over the long term retaining our people. Where adequate expertise is unavailable at home, visiting experts from various universities and technical agencies fill the gap.

Currently we have partnerships with the Canadian associations of surgeons. Our local surgeons are trained by distance with Canadian surgeons and are mentored. There are weekly rounds supported by Canadian surgeons. Therefore, the advantage is that we can keep our people, they are well trained and it is cost effective. This way, even if we lose one or two, we still have capacity. We also acquire capacity to do our own training. And eventually I hope we will have enough capacity to train persons from other developing countries. Some of these ideas can be applied to disempowered first nations within developed countries and other disadvantaged minorities in the developed countries.

2) *You have said in your presentations, "When health suffers, mental health suffers even more." How do you focus priorities so that mental health is not ignored?*

The traditional way has been to see mental health (MH) as not really part of medicine, and I would argue that would be the case in both developed and developing countries. In fact you could argue as well that developing countries have adopted, since policy follows aid, the tradition in developed countries or western medicine of separating mental health from the rest of medicine, a kind of arbitrary mind-body dualism. And even if there is awareness of

mental health in developing countries the emphasis has been on the well known psychiatric disorders such as schizophrenia and bipolar disorder with little emphasis on attachment, trauma, substance abuse and family violence, early intervention and prevention.

Within mental health in developing countries, there is bias as well against such frequently diagnosed conditions as depression and anxiety with the view that depression and anxiety only happens in rich countries. So there are two points to be emphasized here. When there is no education around this, depression still tends to be seen as a character flaw and as epidemiological studies have shown, there is a significant subgroup that have early onset (i.e. in young people) with the result that it is often not diagnosed earlier and as such accounts for significant morbidity or burden of disease in a young person's life.

So there is a lot of work ahead, not just in terms of needing better resources, but better education. As it stands right now, the profile of MH has low priority in national budgets not just because of limited dollars, but poor education around it. Mental Health literacy is low, both in the general population and among public health and medical professionals. On a local level MH is not discussed with other professionals; MH personnel are not missed at meetings of other medical practitioners- no one asks "hey where's the psychiatrist or psychologist or social worker". Conversely MH people don't find the need to talk to their colleagues, so that is definitely a two way street of neglect. But I think the low self esteem by MH practitioners about demanding better services is endemic to developed and developing countries, the tendency to isolate themselves from mainstream medicine. This is a mistake. The onus must be on mental health practitioners to demand greater respect and a genuine place on the health care agenda.

3) *What about prioritizing child mental health or maternal mental health?*

That builds on my remarks from your previous question. MH in developing countries is seen also as an adult problem; people have difficulty conceiving that a child may have problems or a mother may have post partum depression and often the explanation, as I have mentioned, is based on morals and values i.e. child not brought up properly.

So it's the double prejudice against children not supposed to have problems and women's rights or lack of rights. To me it's impossible to talk about children's rights and dissociate this from women's rights. And then again it's immoral to talk about health care without including women's and children's rights.

We have to start insisting that these issues of social justice of children's and women's rights are not add-ons or nice afterthoughts, after other seemingly more important issues have been addressed. Of course people need to be fed and need to feel safe, these are life and death situations but beyond this basic level, it has been a mistake to exclude issues of social justice from other health initiatives.

4) *So how does it get done? How do we enshrine these priorities in the legislation of each country, and at the world body level?*

We are currently revising in Guyana our mental health legislation which is over half a century old. Human rights have changed tremendously during this period of time. There is a much greater awareness of human rights abuses or neglect in those suffering from mental health problems. However, I plan to enshrine within this framework, legislation that protects women's and children's rights which are largely absent from this legislation currently.

Therefore, we will utilize a legal framework to expand and improve health services around women and children not currently mandated. Once you have done this, it has to be done in the context of resources in the country-listing them is a start, otherwise they are off the radar; if they are not listed they will never get addressed. We start off with the assumption that we don't have enough money but that's not the same as saying "well we don't have the money so let's just forget about it." It's a middle position between being hopeful but realistic with the current resources available.

At the same time we have to be wise and not medicalize what are otherwise social issues. In a resource poor context and I suspect this applies to shrinking health care dollars in

developed countries as well, the health care system is not geared to deal with social issues or to solve or be the panacea to all of society's problems. For example, it may be a big issue for you here in Canada on how to deal with the intoxicated homeless people in winter time as they may freeze to death overnight if left outside but in Guyana it is better to let these people sleep it off, or bring them to a shelter rather than a costly emergency room. Similarly I personally know about 30 children who have literally grown up in the hospital in Georgetown because there were no foster homes to send them to. Hospitals or institutions are not geared to raise children. That's not cost effective and it's not good for these children to grow up within the walls of an institution.

After all the paperwork and expert legal advice we are receiving, we hope to export the framework of this legislation to modernize the health legislation in other countries.

5) *You are also active at the WHO level. What is the framework there around MH legislation?*

Can I be candid here? There was an entire WHO report in 2000 dedicated to MH issues, but since then nothing has happened. Once again mental health issues got overshadowed by other seemingly more urgent issues such as HIV and malaria control. So when it boils down to competing for resources, mental health will always lose out since there is always a more pressing or urgent issue. On the other hand given the constant constraints of resources, WHO needs to use its prestige to focus on areas that need energizing like mental health. WHO has to engage more effectively in providing mental health leadership. Its weak leadership in mental health impairs its effectiveness in promoting mental health progress in the developing countries. In this regards, we need a paradigm shift at the WHO so that they may gain legitimacy as a genuine leader and advocate for mental health. Only then could the WHO provide leadership to address the gap in these countries.

6) *In your own country, you managed to get funding for mental health from 100 k to 1 million; how did you do that and how can it be done in other similar countries?*

We did increase actual funding for mental health, but I also increased mental health services by piggybacking mental health issues onto other disorders such as HIV and cancer. Mental health programs don't always have to come from a MH unit-the addiction program for young people can be funded through adolescent wellness. There is no reason why when HIV personnel travel to remote areas that MH personnel can't go with them. Medicines for mental health can come from other budgets outside of mental health. So basically the strategy is not to totally disaggregate the mental health department or personnel from other services but to integrate, when possible, mental health in the overall service. Through the integration of mental health, the primary health care system, certain aspects of the mental health funding can be taken care of, outside of a dedicated mental health budget.

Hopefully, this leaves budgets for other more neglected mental health issues such as children's and maternal mental health issues but I can see even these being integrated into shared care models with a focus on the whole family at the primary care level. In addition, Guyana had persuaded funding agencies, such as the IADB (International Development Bank) and Global Fund to support the mental health programme.

7) *You have been quite vocal about stating that not only does aid have strings attached, but also that donors get benefits in return- that there are things to learn from each other.*

There is a certain psychology at work such that even in countries with relatively more resources, we personalize the constraints and think that we are the only ones deprived.

Even in resource-rich environments, there are constraints- resource constraints exist across the board. As the need is always growing, developed countries cannot keep finding resources to deal with morbidity, and need to address issues that improve conditions now so that people don't depend on the state to take care of all their health needs.

Collaboration can be of mutual benefit- for example developed countries can learn how we have learned to provide comprehensive health

with less- in that respect developed countries may learn as well how to get more value from their investments. For example in Guyana there are five levels of care tailored to the complexity and frequency of the health care problem starting with community health workers. These are health posts in every community to provide mainly preventive care. At level 2 immunization, family planning and antenatal services provided. Level 3 introduces the community hospital while Level 4 is the Regional Hospital where a comprehensive secondary health care service is provided. Level 5 is the National Referral Hospital.

While developing nations appear to look with envy at the resources available in developed countries, the evolution to modern technological societies has come at a cost in terms of losing their own community - based resilience. Let's remember that not so long ago elders or traditional helpers did deal effectively with some of these issues. We need to look at community resilience, the innate capacity communities have to heal and take care of its citizens and we should try to find ways to support these innate resources. Professionalization and specialization have created new barriers. In resource poor countries-there are opportunities to do things not hampered by burdensome laws, or other competing interests, especially the rogues associated with special interest groups.

As I mentioned above there are some things the community does best and the medical model is not suitable-for example, psychosocial issues such as grief and bereavement issues. So it is not only new skills that are needed but also looking at what existed before so it can be a comprehensive way for communities to deal with their needs. At the same time the types of models we have developed could apply to disenfranchised groups within developed countries, especially groups suffering from cultural dislocation who need to preserve their cultural heritage.

8a) *You are quite passionate about how developed countries actually steal your personnel resources (outmigration).*

Well that's a no-brainer and another aspect of how aid is not just a one way street from donor to receiver. How can we compete with Toronto or New York offering a salary for a nurse or an MD that is ten or twenty times the amount that we can afford? I might sound like a Marxist or a socialist (I understand these terms inspire great fear in the hearts of your neighbors to the south) but let's say we train 10 people in our country and five leave, that is still an acceptable situation but when the whole ten leave then that is very disheartening. There must be international agreements that ensure countries benefit from their own trained personnel.

8b) *So what can you do about this?*

First, we need to train more persons locally. We need support to build greater capacity for local training. Second, we need greater international attention to restrict poaching and for us to have a global group of personnel to plug gaps where human resource deficiency can lead to serious health gaps.

9) *You made me laugh when you spoke out against too many studies and consultants as a waste of time and money. Care to elaborate on that?*

Don't get me wrong, there is a place for studies and consultants. We all need help. It's the model of getting the help. We perpetuate this thing of writing reports leaving very little left over for the actual work. The reports and recommendations become useless because resources are then not available. Additionally, even if we did have the resources, we often lack the technical know-how. So on a practical level let's look at how to get the thing done rather than an esoteric consultant's report. I'll give you an example. There were many studies done on micronutrient deficiency in Guyana but nothing got done. I then initiated collaboration between the University of Toronto and Heinz to produce sprinkles and that solved the problem. The studies simply told us what the micronutrient deficiencies were. The funding agency then wanted to hire a set of consultants to recommend how to address the problem. I resisted. Instead, I proposed that researchers at U of T assist us to design a sprinkle mix that could be added to the food of children and pregnant women. The U of T scientists did not have to leave Canada and their services cost nothing. Heinz Canada then assisted a local company to manufacture the sprinkles, ensuring

that the necessary quality control standards were in place.

What we have found to be more cost effective is to get university departments to work on a problem (for free or whatever small amount we can pay them i.e. a stipend for one of their students to come visit us) so that the whole faculty or department develops the tools necessary both conceptually and practically. After all, isn't that what universities are for? Universities need to develop more effective learning and teaching tools.

10) *You mentioned the American management warehousing model which made me cringe at first but actually sounds like it might have some merits?*

There could be no good health care unless we have medicines and commodities. The problem is that a supply chain rarely exists in developing countries. The SCMS (Supply Chain Management System) partnership came to us through the US HIV Program (PEPFAR). But we were able to convince the US that we cannot deliver effective HIV treatment and care unless we have a functioning supply chain. Today, Guyana has an effective Supply Chain System, fully computerized and able to keep track of who needs supplies and how they are using it.

This type of program could now be implemented in other countries so that others don't need to re-invent the wheel.

Thank you Minister for your insights and your courage. You truly are an inspiration for the rest of us.