# Fighting Depression, One Village at a Time

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July 18, 2012, New York Times

What is the most burdensome disease in the world today? According to the World Health Organization, the disease that robs the most adults of the most years of productive life is not AIDS, not heart disease, not cancer. It is depression.

The disease is not merely a bourgeois problem. It is especially prevalent in places that have experienced war, disaster or crushing deprivation. Yes, in many poor countries the bonds between people are much stronger than they are in wealthier, more individualistic societies, and this is a good thing for mental health. But it can hardly counteract the fact that a lot of people have an awful lot to be depressed about. Violence — whether war or high rates of crime — produces widespread post-traumatic stress. The constant worry that a crop failure or serious illness will throw a family into poverty is a source of extreme anxiety. Seeing your children go hungry creates paralyzing guilt.

According to the World Health Organization, three-quarters of the world's neuropsychiatric disorders are in low-income or low-middle income countries.

In troubled places, depression's impact is more severe. Most families have no cushion or safety net — they are running very hard just to stay in one place. A parent who is too depressed to work can bring a family to ruin. In wealthy countries, we grasp how debilitating mental illness can be, and we treat it. (Unevenly — the disparity in access to mental health care between rich and poor in America is enormous.) In poor countries, attention to mental health has been close to zero. The conventional wisdom is that treating depression in countries where there are myriad other problems is a luxury. Besides, how could it be done? Drugs are expensive, and the vast majority of poor countries have virtually no psychiatrists or psychologists outside of private clinics.

Until a few years ago, no one was even asking this question. Today, not only is mental health getting global attention, mental health care is successfully expanding in many poor countries, including India, which announced a new national mental health care plan at the end of June. The strategy is the same one that is preventing and curing disease all over the world where health care professionals are few: task shifting. That means training and supporting people with lower levels of education to do the work of doctors and nurses.

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Amadi was inside her hut, sitting in the semidarkness, when a local woman named Christina Nanyondo came to her door to invite her to do something that would have been unheard-of in her Ugandan village before: join a therapy group for depression. She was 59, and had lost five of her nine children in the last 10 years, three of them to AIDS. She was numb and passive, sad and irritable. She could not care for her family, work in her garden, or do her mat-weaving.

At first Amadi (a pseudonym) had no use for any therapy — "all the treatment in the world won't bring my children back," she told Nanyondo. But at Nanyondo's urging, she joined the group.

The sessions, part of a study designed to test whether interpersonal therapy, which has proved as effective as medicine at curing major depression in Western settings, can work in rural villages. The group, consisting of eight women, began meeting with Nanyondo as facilitator. They met weekly, first spending their time describing their problems, but gradually comforting one another and suggesting steps to take. Together they visited the graves of their loved ones and held a formal mourning service. The women all became active in the community, and each talked to her own family members about H.I.V. infection and how to prevent it.

All the women, including Amadi, gradually got better. Eighteen weeks after starting therapy, Amadi had no more symptoms of depression. She was once again, to use her husband's words, the fierce, loving, strong woman she had been.

Amadi's story was described by one of the organizers of the study, Helena Verdeli, an assistant professor of clinical psychology and director of the Global Mental Health Lab at Columbia University's Teachers College. By accident, the study also did something else just as significant. The researchers were working with the Christian humanitarian organization World Vision, and had intended for the groups to be led by World Vision's trained health workers — nurses and health counselors. "But they couldn't spare any," Verdeli said. "They said, 'don't worry, we're going to hire their younger brothers and sisters.'" Some were in college. Some, including Nanyondo, had only a high school degree. Yet the treatment was overwhelmingly successful: six months after beginning therapy, only 6 percent of the people treated still had major depression. This study, which took place in 15 villages, was proof that effective therapy for depression could be delivered in the poorest of settings, by lay people.

There have been other studies confirming that when done correctly, community members with minimal education can effectively treat depression. One of them took place in Goa, India. Nearly 3,000 people with symptoms of depression or anxiety were randomly assigned to receive normal services in their usual public or private clinics, or to be treated by young local women who had taken an 8-week course in interpersonal psychotherapy. Six months later, 66 percent of the patients in the public clinic who had gotten that therapy had improved. Of those who didn't get the therapy, only 42 percent had improved. (At the private clinics,

where patients normally had their own doctors and better care, the doctors and the lay workers did equally well.)

Another study in Pakistan gave community health workers — women who had completed secondary school — a two-day course in listening and basic cognitive behavioral therapy. They were shown how to integrate these things into their regular visits to pregnant women and new mothers. Even that brief training made a huge difference: a year later, only a quarter of their depressed patients were still depressed, compared to 59 percent of the control group.

Interest in global mental health care was awakened by a World Bank-commissioned study in the early 1990s looking at the global burden of disease. While most research had concentrated on what causes death, this one examined disability — and found the shocking burden of depression.

The World Health Organization got involved, devoting its world health report to mental health in 2001. Four years ago, the W.H.O. started the Mental Health Gap Action Program. It pushes for greater attention to mental health in poor countries and provides technical support and guidance, mainly about how to include mental health care in primary care clinics, and train community health workers.

The tremendous prevalence of depression also caught the attention of organizations making big investments in child health and treating AIDS, tuberculosis and other diseases. It was clear that depression was keeping these programs from working as well as they could. “People on the ground realized that adherence to treatment is important,” said Mark Van Ommeren, the director of mental health in emergencies at W.H.O. “But people with mental health problems are less likely to adhere.”

“The question was how do you close treatment gaps where there are hardly any professionals,” said Vikram Patel, a psychiatrist at the London School of Hygiene and Tropical Medicine, who also works in Goa with the nongovernmental mental health group Sangath and was the lead researcher on the Goa study. “It got people thinking: how have other people closed treatment gaps in maternal and child health for the last 15 years?” They used task-shifting — Patel prefers to call it task-sharing. “So we can do it for mental health,” he said. He has been extremely influential in shaping India’s plan, which includes a new cadre of community mental health workers.

Task shifting is happening even in wealthy countries to close treatment gaps; hence the rise of the nurse practitioner as physician substitute. But it’s very widespread in poor countries. Across Africa, nurses and clinical officers do the work of doctors in treating AIDS. In Africa and Asia, a few days or weeks of training enable barely literate women to improve the health of their villages. When doctors are present — if they are present — their role has changed; they now supervise the others and see only the really hard cases. “It became very clear

it was possible to train lay members of the community to do fairly specific things and do them well," said Harry Minas, a psychiatrist who directs the Center for International Mental Health at the University of Melbourne.

But new programs required new money, and this was present only in a few countries — usually as a result of crisis. Sri Lanka and Indonesia's province of Aceh both had long-running civil conflicts that traumatized much of the population. But they started getting access to treatment for that trauma only after the tsunami of 2005. "The number of people affected by the tsunami pales in comparison to the people who had trauma from the conflicts," said Greg Miller, who reported on mental health care in Aceh for Science magazine. "But in both places mental health care didn't exist — nothing there. With the tsunami, there was a huge outpouring of support specifically geared towards improving the mental health of survivors."

In the past, perhaps, international aid might have paid for stand-alone treatment centers that would last only a few months, the therapy delivered by outsiders, with little local training or participation. Now, instead, most of the money was employed to build mental health care into the government's health system, using task shifting. The visiting psychologists and psychiatrists were there to train locals.

Lay people in Aceh learned how to identify symptoms of depression, and how to work with patients' families and support their treatment in the community. Nurses were trained in psychotherapy. Doctors learned how to treat patients with a limited number of psychiatric drugs.

Now 85 percent of health centers in Aceh have some staff with mental health training, Miller wrote. Sri Lanka, which has a similar system, is now expanding it beyond zones hit by the tsunami.

Kosovo, building a health infrastructure after the end of Slobodan Milosevic's war, found a different and very creative solution. Serbia had barred Albanians in Kosovo from getting formal medical education, and after the war Kosovo had only five clinical psychologists and 19 psychiatrists for its two million people.

"Our needs were very high, and the human resources to respond were very low," said Ferid Agani, a psychiatrist who led the construction of the new mental health system, and today is Kosovo's health minister. "The natural answer was to rely on family structure. Families are very strong here, very connected. Before, our model was centered on medication. We wanted to train teams in providing complete services based on family resilience. What could be better than having this resource?"

With advice and training from a group of doctors from the American Family Therapy Academy, Kosovo set up workshops for patients and their families, where they learned about the patient's disease and how to help. Several families

were trained together, creating support groups. Meanwhile, the medical schools graduated professionals — now there are 60 psychiatrists and 600 clinical psychologists. Agani said that hospitalization is down by 60 percent and results are better.

Why did it take so long for health experts to see what now seems obvious: just as all people need access to health care, we all need access to mental health care. If depression can paralyze people who have everything, how could we ever have thought that it didn't affect people who have nothing? "There's an assumption that after you bury five of your kids you get used to it, and it doesn't hurt as much," said Verdeli. "People don't realize you don't get used to it. You just give up."