PAKISTAN MENTAL
HEALTH COALITION

Pakistan Mental Health Advocacy Landscape Analysis

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The report was authored by
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on behalf of
Pakistan Mental Health Coalition

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Introduction

The Pakistan Mental Health Coalition came into being as a combined response of organizations working in mental health to address the concerns during the COVID-19 pandemic. The coalition soon became a focal point for changing the mental health climate of Pakistan and organized itself to initiate advocacy efforts within the country.

Pakistan Country Profile was the first report published, which aimed to capture the mental health landscape in Pakistan, along with the current gaps. As a result of the report, an advocacy sub-committee of the Pakistan Mental Health Coalition (PMHC) was created to highlight the gaps in mental health advocacy in Pakistan which culminated in the development of a detailed gap analysis. This analysis was further combined with the existing gaps identified by the subcommittee and consolidated into a complete gap analysis of the country's mental health framework, including legislature, program implementation, healthcare quality and healthcare financing.

A series of meetings with stakeholders within the ecosystem were conducted. This ensured that any gaps within this identified analyses were further discussed. Moreover, all advocacy efforts within the country were tabulated into a single report for the success of future advocacy initiatives and for the coalition to guide mental health advocacy efforts within the country.

To engage with remaining stakeholders on the above issues and identify gaps in the mental healthcare ecosystem of Pakistan, a series of stakeholder meetings was conducted by PMHC between July and August 2021.

The objectives of the meetings were:

1.) To identify potential opportunities for mental health advocacy in Pakistan.

2.) To map different mental health advocacy initiatives being led by relevant actors.

3.) Consolidate the work being done within the mental health ecosystem of Pakistan into a single document for future advocacy efforts

Attendees to the meetings included:

Name	Designation
Dr. Rubeena Kidwai	Director Training and Quality Assurance, Self-Empowerment Pakistan Member, Sindh Mental Health Authority
Dr. Salma Khalil	General Physician, more than 25 years of experience working across Pakistan. Working with Autism Spectrum Disorder Welfare Trust (ASDWT) since 2015

Dr. Qudsia Tariq	Head of Department of Psychology at Karachi University
Dr Uzma Ambreen	Vice President, Pakistan Association for Mental Health
Professor Mowadat Hussain Rana	Founder, The Healing Triad Advisor to Pakistan Mental Health Initiative, Red Crescent Founding Secretary General, EMDR Pakistan, EMDR Asia 2010
Dr. Murad Moosa Khan	Professor Emeritus, The Aga Khan University (AKU) President, International Association for Suicide Prevention Member, International Academy of Suicide Research
Muqaddisa Mehreen	Child Protection Specialist, UNICEF

Background

The Islamic Republic of Pakistan is a country in the South Asian region under a parliamentary democratic system. The Ministry of National Health Services, Regulations and Coordination is responsible for national level provision of medical services, health policy formulation and enforcement. However, following the 18th amendment to the constitution in 2010, health care management was decentralized and the responsibility was given over to the four provincial governments.

The health system of the country is made up of urban and rural primary health care Basic Health Units with referral facilities for acute and inpatient care through Tehsil and District Hospitals. Few mental health services exist for a population of about 200 million, and existing resources lack effective leadership, are poorly organized, concentrated in urban areas and predominantly treatment focused, with little attention paid to preventative and promotional efforts.

The World Bank categorizes Pakistan as a lower-middle income country. In 2016, an estimated 4 out of 10 Pakistanis were found to live in poverty, and face severe deprivations in access to health, education, and standard of living. Healthcare in Pakistan is funded by contributions from public, private, and philanthropic sectors, with investment largely focused on tertiary care.

Mental health has been a neglected priority within the country. Until 2021 there was no centralized body to oversee mental health provision and gaps within the country. This task is currently being handled by the Mental Health Task Force, which has been set up to evaluate gaps in the mental health infrastructure of the country and come up with policy frameworks to bridge these gaps.

The legal framework for mental health was updated in 2001 via the Pakistan Mental Health Ordinance which repealed the outdated Lunacy Act of 1912. The ordinance was proposed and developed by the government after a round of revisions sought by psychiatrists. No individuals with lived experience were consulted in the development of the 2001 Ordinance. It was launched with the goals to amend and strengthen the laws surrounding treatment and care of people with mental health conditions as well as make better provisions for the management of their legal affairs.

Research on the prevalence of mental health conditions in Pakistan have significantly varied findings and these rates should be reviewed with caution. The three most prevalent mental illnesses in Pakistan are reported to be depression (6%), schizophrenia (1.5%) and epilepsy (1-2%), however, this information is obtained from a dated source and limitations around reliability and under-reporting are not acknowledged. Pakistan has a large youth population, with 62.7% of the population being under the age of 25. Yet youth mental health is a starkly neglected area of work and research in the country despite a concerning rise in youth suicides and cases of child abuse reported. There are only three Addiction Treatment & Rehabilitation Centers to provide free treatment, boarding, and rehabilitation for the number of people affected by substance abuse in the population i.e., 6.7 million users. This gap also calls into question the country's ability to cope with the lack of resources available for rehabilitation services required.

Pakistan has a patriarchal social system which disadvantages women; violence against women and girls is a common problem in the country, leaving long-lasting negative effects on women's wellbeing and health. In the most recent national survey, up to 28% of women aged 15-49 had reported experiencing physical violence in their lives. Among women who've experienced sexual violence (6%), 78% reported their husband as the perpetrator.

Culturally, mental health problems are still commonly perceived to be the result of supernatural causes or divine punishment/test, which stigmatizes people with mental health conditions and creates barriers to accessing care. Religious and faith healers are often the first point of contact for help seeking due to their powerful standing in many local communities.

Pakistan has a telecommunication penetration of 78.16% and there is a significant shift towards digital solutions to address the inequality in access to care. Social and healthcare programs are now utilizing telecommunications as a means of increasing access for mental health and social services within the country. The recent COVID-19 pandemic and subsequent country-wide lockdown has further increased the update of these technologies and is creating new avenues for healthcare equity. Challenges for regulation of social media and tele-health remain, however.

Pakistan is vulnerable to a variety of natural hazards such as cyclones, droughts, floods, landslides, and earthquakes. Many of these natural disasters e.g., the 2005 earthquake in North Pakistan and 2010 floods, caused unprecedented loss of lives, hundreds of thousands of casualties and left many millions displaced and homeless. The impacts of these disasters had long lasting implications on the health and well-being of those most vulnerable. A study conducted in the Northern regions of Pakistan after the 2005 severe earthquake that killed 73,000 people found that 55.2% of women and 33.4% of men were found to be symptomatic for PTSD. Many families continued to live in temporary housing conditions for over 1 year post the disaster, but communal living was seen to be a protective factor due to familial and social support in the challenging situation. Pakistan has struggled with ineffectual political leadership since shortly after its independence in 1947 and there is widely prevalent public mistrust of the government.

The inability of the government to bring stability has created a hostile and unlawful environment in almost all the systemic institutions within the country, and especially within the Northern areas of the country where extremism is still prevalent. Vulnerable groups like children and young adults from the northern province of Khyber Pakhtunkhwa suffer from the worst of the politically instigated violence and insurgency. A study conducted found extremely high levels of PTSD symptoms (16 out of 17 symptoms as set by the DSM-IV) in young people aged 11-12 years in trauma survivors of suicide attacks, explosions, and long cur few hours.

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Gaps and Opportunities Analysis

Category	Sub-Category	Current Status	Gaps	Past and Current Activities
Legislation	**Federal**	A. 2001 Mental Health Act exists and covers central legislative and policy direction. B. Pakistan Mental Health Task Force established in 2021 to bridge gaps from 2001 legislation.	A. No Federal Policies exist that were passed or amended in the last decade. B. No standard operating procedures from the Act are currently being implemented or utilized as intended. C. No social scientists, public health professionals or people with lived experience were involved in writing the law D. Categorization of mental illnesses needs to be updated to current standards. E. Data gathering prior to policy finalization is not as per the current criteria	A. Dr. Mowadat Rana was involved in the 2001 Mental Health Ordinance and provided context on the passage of the law. B. Future agendas for improvement in legislation have been proposed by Dr. Rubeena Kidwai. These include regulation of Psychologists as well as the creation of an apex body to register and enforce these regulations.
	Punjab	A. Punjab Mental Health Amendment Act of 2014 is the guiding tool for Punjab province. B. It serves to define provincial laws, rules, and regulations.	A. Individuals with lived experience absent from composition of authority. B. Vague language leaves portions of the act open to interpretation including those for bypassing informed consent in cases of psychiatric admission and discharges.	
	Sindh	A. Mental Health Act of 2013 & Mental Health Rules 2014 are the guiding legislature for mental health for the province.	A. Does not regulate psychologists and focuses on psychiatrists only. B. Definition of mental disorder is poorly defined and open to interpretation. C. Legislation's language is vague and open to misinterpretation in	A. Dr. Uzma Ambreen has worked on the Sindh Mental Health Act of 2013 and attempted to alleviate some of the gaps left by the 2001 Mental Health Act.

			many areas.	
	KPK	A. The Khyber Pakhtunkhwa Mental Health Act of 2019 is the guiding document.	A. Individuals with lived experience were not part of the consultation process for defining the laws. B. Issues of terminology, consent for admission and release remain problematic areas like the Punjab act.	
	Balochistan	A. The Balochistan Mental Health Act of 2019 is the guiding document.	A. Individuals with lived experience were not part of the consultation process for defining the laws. B. Vague language allows for broad detention of individuals with mental health issues without clear demarcation of circumstances.	

	Healthcare Quality	A. Healthcare Quality and Healthcare Management paradigms not part of current policy & legislature.	A. Healthcare Quality experts not consulted to ensure that there are SOPs and methodologies to track compliance for In Patient Psychiatric facilities & measures to manage Out Patient Counselling/Therapy.	A. Dr. Rubeena has introduced standards of Care/ Code of Conduct for different mental health service providers and systems and processes to address quackery & malpractice in the field of mental health.

	Regulation of psychiatrists	A. National and Provincial policies & legislature along with PMC regulates psychiatrists.	A. No set standards for prescribing, B. Oversight by PMC only for cases of reported complaints. C. No annual guideline reviews nationally or process of revalidation, most psychiatrists keep updated on their own accord creating gaps in D. knowledge/practices. E. Prescription guidelines and review not operationalized.	
	Regulation of Psychologists.	A. Not defined at present.	A. Standards, guidelines etc. for ethical practice not in place. B. Implementation of guidelines etc. not tracked as no regulatory bodies are in place. C. Personal beliefs and preferences lead to advice & practices rather than standards and guidelines.	A. Dr. Rubeena has collaborated with the Sindh Mental Health Authority which is concentrating on the gaps in legal terms for the province to ensure proper regulation of psychologists.
	Mental health promotion and primary prevention of mental illness	A. Key defined areas are the focus of current policies & legislatures.	A. Access to care, access to therapy/counselling services and access to preventative measures is not prioritized. B. Mental Health infrastructure does not include social workers and occupational therapy C. Inverted pyramid where tertiary prevention is prioritized over primary and secondary prevention.	
	Patient Care Standards	A. At present not defined.	A. No In-Patient or Outpatient Psychiatric Guidelines & Standards maintained for existing Psychiatric facilities. B. Lack of Standard National Guidelines results in no compliance standards. C. Healthcare Quality paradigms	

			are not reflected in care of psychiatric patients.	
	Psychosocial intervention	A. At present not defined.	A. Psycho-social aspect of mental illness not understood or propagated. B. Misinformation & lack of clear guidance for public and policy makers leads to focusing efforts solely on medical treatment. C. Mental Illness among under 25, 62.7% of the Pakistani population, not prioritized. D. Substance abuse, lack of healthy coping mechanisms, anxiety & depression not catered to at early stages creating an increasing prevalence of mental illness.	
Financial	**Payment models**	A. Most Mental Health services are based on self-payment models.	A. Current system reduces the overall access for care of services. B. Limits services to only those individuals that can pay for services out of pocket.	
	Universal Health Coverage	A. Mental Health coverage not currently included in UHC.	A. This sustains the fee for service model for private practitioners and ensures that most Pakistanis cannot seek access to mental health services. B. Lack of UHC coverage also decreases overall spending for mental health services and prevents existing service delivery standards from being implemented for coverage	
	Private Health Insurance	A. Currently the widest form of healthcare insurance in the country.	A. Private Health Insurance often does not cover psychologists & counselling. B. This creates an inverted pyramid where coverage is only	

			given for medication lead practices such as psychiatry rather than counselling & therapy C. Care is only provided when mental illness becomes debilitating, and individuals have suffered significant morbidity	
	Overall Spending	A. Overall expenditure on mental health, estimated to be only 0.4% of health spending in Pakistan.	A. Creates a model where prevention is not prioritized over treatment/health management modalities. B. Decreased spending sustains financial losses (estimated at $5.4 billion annually) and reduces overall productivity & quality of life.	

Research	**National Mental Health Surveys**	A. No progress at present.	A. Most data originate from private studies and variations in sampling and designs leads to results skewed for Pakistan's urban population. B. Rural populations continue to be neglected for mental health services, access & research. C. No national or provincial indices for mental health have been established. D. No tracking of indices or methodologies to tie in public mental health interventions with the acts in the legislature.	A. Dr. Murad Moosa Khan has been researching suicide and suicide prevention in Pakistan.
	Youth Mental Health Surveys	A. No progress at present.	A. Prevalence studies for under 25 not prioritized. B. The bulk of Pakistan's population is under 25 and not fully represented in policy decisions.	

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Conclusions and Recommendations

Overall, the meetings provided an opportunity to exchange ideas on key advocacy priorities and identify key stakeholders in these efforts. While there are some passionate advocates who have achieved much, there is a lot more work to be done to address the various issues arising out of the gap analysis.

Legislation and Policy

The coalition will need to strategize on where its focus on legislative and policy advocacy needs to be. Currently there are several efforts underway at the federal level, specifically around decriminalization of suicide, and with respect to the Bill on the allied healthcare professionals. PMHC and its members are actively involved in these advocacy targets. It may be expedient to also strategize around opportunities for advocacy at the provincial level. And provincial leads could be appointed within the coalition to promote provincial level advocacy. Dr Rubeena and other member organizations have a close liaison with the Sindh Mental Health Authority. GIHD, Taskeen and others have close linkages at the federal level. UNICEF has a strong focus in KP. As a coalition we can leverage these relationships for our advocacy goals. However, the coalition will need to identify its own priorities.

Program Implementation

In the gap analysis, it was indicated that there is a lack of programs. During the stakeholder meetings we have learnt from the members that COVID-19 has resulted in a huge surge of free mental health helplines and teleconsultations sponsored by different donor agencies including WHO, UNICEF and British Asian Trust to name a few. These agencies have worked with both governmental and non-governmental partners to create access to the masses. Though this is a huge advancement in tele-mental health, these helplines were set up as a reaction to the pandemic and no comprehensive plan to deliver mental health services was available with either the federal or provincial governments to proactively respond to increasing burden of the mental health issues.

Before the pandemic, there were only two national helplines available run by the non-governmental sector organizations. Other than that, all the treatment and rehabilitation is based in tertiary care hospital setup. So, the bridge between reactionary helplines and tertiary care setup must be made by initiating and integrating mental health services at the primary care level clinics. These need to become part of the regular services provided by both public and private basic healthcare units. Basic mental health services also need to be integrated into universal health coverage.

In addition to initiating mental health integration programs at the primary healthcare level, the capacity of the allied healthcare workers employed in these setups also needs to be built. Currently, mental health is not in the curriculum of Lady Health workers, nurses and general physicians are not given hands on experience to screen, provide support and refer when needed for mental illness.

Moreover, there is no regulatory body for clinical psychologists that can regulate and license the psychologists meeting the criteria to practice. Some efforts are being made to get relevant legislation passed in this regard. These efforts needs to be supported and when it is approved it is needed to be implemented both at federal and provincial level. We also need to regulate mental health clinical facilities like any other mental health facility.

Research

Currently no national surveys include clinical indicators of mental illness, nor do they capture prevalence of psychiatric illnesses, not even the major illnesses like depression and anxiety.

Pakistan Demographic Health Survey currently captures some indicators on quality of life. There have been research projects in academia on different aspects of mental illnesses but very few are in the form which can study the long-term dynamics of the illness and still fewer are clinical trials trying to find out the direct causes and treatment for mental conditions.

So, to better understand the burden of mental illness, it is important that we should study prevalence through national surveys including Pakistan Demographic Health Survey and National Health Survey. Moreover, the prevalence of mental illnesses should also be recorded in the district health information system and with the same system suicide and its means should be recorded in the Disease Early warning system of the government to alarm where suicides are increasing to address the underlying causes in those areas.

Finance

We saw no examples of advocacy for greater resources allocation for mental health in government budgets, specifically for primary care level. However, there are efforts underway by the current government and WHO to introduce Universal Health Coverage and mental health is one of these components. GIHD is working closely with the federal government to promote MH as part of UHC. To better understand resource allocation for MH, a health budget analysis would need to be conducted to understand financial gaps.

Beyond government there is a need to advocate for financial resources towards mental health from private donors as well. The PMHC can play a role in this.

Healthcare financing efforts are vital to ensuring that Pakistan sustains itself in the adverse climate described above. The PMHC advocates for the federal government to allocate at least 5% of health expenditure for mental health services and national programs with an expanded focus on community-based services and promotion and prevention initiatives integrated across multiple sectors e.g., Education and Social Welfare.

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