Emergencies and disasters as opportunities to improve mental health systems: Peruvian experience in Huancavelica

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The paper describes the development of a community oriented mental health care system in the Region of Huancavelica (Peru), after a devastating earthquake in 2007. The area is also one of the most inaccessible and disadvantaged areas of Peru. Collaborative efforts by health personnel in the area, the Regional Directorate of Health and the international organization Médicos del Mundo – España, led to a wide range of activities such as: 1) the revitalisation of a dysfunctional Community Mental Health Centre; 2) the development of a Regional Mental Health Plan, through an participatory process; 3) a pilot action research project in the community to identify people with severe mental health disorders who did not receive psychiatric care; 4) the training of general health personnel in mental health and 5) support a mental health reparations programme for survivors of political violence. The authors argue that emergencies and disasters can be an opportunity for fundamental changes in the mental health care that would be very difficult to implement at other times. The first six months of reconstruction after a disaster represent a privileged time for non-governmental organisations to assess the local mental health care systems, and work hand in hand with survivors and the authorities to elaborate longer term projects and mobilise the necessary support.

Keywords: earthquake, health reform, mental health care systems, mental health plans, Peru

Background

Médicos del Mundo-España (Doctors of the World-Spain, MDM), an independent international aid organisation, has defined psychosocial and mental health work as one of its priorities. Since 1994, MDM has developed programmes in Spain and many other locations including Bosnia, Kosovo, Palestine, Sri Lanka, El Salvador, Guatemala, Mexico, Peru, Colombia and Haiti by providing support to national and regional mental health programmes, supporting local organisations working with specific groups, and developing mental health emergency actions. Over the years, the organisation has been developing a project model focused on supporting public health models and transforming the population's living conditions from a starting point of war, emergency or disaster. In the countries listed above, mental health systems are usually nonexistent or underdeveloped and therefore considered strategic by the organisation.

Aid work, in response to disasters, has traditionally placed a priority on detecting

and responding to the immediate needs of the surviving population. However, particularly in societies struck by political violence, it is also important to pay attention to structural conditions underlying the emergency, and the analysis of vulnerabilities and capacities (Anderson & Woodrow, 1998). It is also important to focus on opportunities for structural change. A crisis situation can create such a potential for change. Opportunities may arise from the need to reconstruct, and therefore, also the opportunity to re-plan and redesign interrupted or underdeveloped health care structures, as well as the arrival of external aid providing additional sources of qualified technical personnel and financial resources. This report focuses on the work being carried out in the region of Huancavelica (Peru). It briefly summarises the experience of (re) planning, and the development of the mental health care system in coordination with the Pan-American Health Organization (PAHO), national and regional government, health workers and civil society, through using the crisis as an opportunity for change. Similar approaches have been developed, or are being developed, in Sri Lanka, the occupied Palestinian Territories and Haiti.

Project context

The Huancavelica region is located in the central Andes of Peru, and is the poorest and least developed area of the country. Its population (475,000 inhabitants) is predominantly rural, Quechua-speaking, and living in scattered communities. Its inhabitants have suffered centuries of marginalisation, and ethnic and cultural discrimination. Between the years 1980 and 2000, Huancavelica was one of the regions most affected by the armed conflict between the Shining Path (*Sendero Luminoso* in Spanish), a Maoist insurgent guerrilla organisation, and the Peruvian Government. The population suffered devastating massacres, systematic disappearances, torture, sexual violence, and forced displacement, from both sides. This war, combined with an extreme level of poverty (70% of population subsistence living) left an indelible mark on the region's people and communities, breaking down community and family support networks (Truth and Reconciliation Commission (TCR), 2003) Fig. 1.

The region's geography is very complex. Situated in the Andes, at over 4000 metres above sea level, its communities are inaccessible. There is only one asphalt road crossing north to south, and the rest are dirt tracks that are impassable in the rainy season. Therefore, significant geographical, cultural and economical barriers prevented patients from outside the regional capital to receive care. The population is widely dispersed in small communities and, above all, there are extreme levels of poverty and exclusion (Instituto Nacional de Estadística e Informática (INEI), 2010). There are also cultural factors involved, most of the population is Quechua-speaking and influenced by idiosyncratic views on health and disease, causal explanations, forms of seeking help and healing, and the importance of social and family ties in the process of falling ill (Elsass, 2001). It is not surprising, therefore, that the population does not use health centres even when available, not because they resort to traditional healing (very basic and debilitated nowadays) but because they are not used to it. They simply treat most diseases at home with local remedies (Rivera, 2003). These beliefs have serious implications for mental health care and intervention strategies.

Mental health care was virtually nonexistent in 2007, with only five psychologists working

Figure 1: Map showing violent incidences - number of official victims per region.
Huancavelica: 13,523 Source: Reparations Council.

in the health or the educational system over the whole region, and a very low demand for care limited to some psychosocial problems presenting to rural health posts (family disputes caused by alcohol consumption, school failure in children, suicide attempts and teenage pregnancy). These cases were referred via primary care. The Peruvian Truth and Reconciliation Commission (in Spanish: *Comisión de la Verdad y Reconciliación* (CVR)) (June 2001–28 August 2003) proposed a Comprehensive Reparations Plan (*Plan Integral de Reparaciones* in Spanish) that was mostly not met, but that allowed the hiring of 14 more psychologists in the region. There is no mental health care training available in Huancavelica, and those accepting work in the region have had urban training. Most professionals lack even basic skills in community intervention, preventative approaches, or inter-cultural approaches. The Ministry of Health and the international cooperation programmes have made considerable efforts in providing training, including the AMARES Project (a programme to modernise the health sector, financed by ECHO, European Union) and the Project of Comprehensive

Healthcare for People Affected by Violence (financed by the Japan International Cooperation Agency (JICA)). However, due to poor working conditions and hardship, it is very difficult for professionals to remain in the region, and once they finish their short term contracts, they prefer to go to other regions in the country. As a result, training efforts get lost again and again.

Even so, the number of professionals has gradually increased to almost 20 currently, distributed among the 51 health centres located in the region, and one mental health centre run by the Huancavelica District Hospital. Paradoxically, this marked progress in human resources did not translate to a substantial change in the number or profile of patients attending, nor did it encourage any community inclusion in decisions over future action. Furthermore, one psychiatrist spent these first years engaged in little more than administrative work. Nor did the increase in professionals lead to the creation of functional structures for guiding and lending consistency to working groups, with specified goals and objectives, and action plans based on local requirements.

In addition, there are unique problems to the development of systems. There is a lack of an integrated epidemiological and data collection system, as well as a shortage and discontinuity of psycho pharmaceuticals available to patients, caused by the lack of training of general practitioners who do not consider psycho pharmaceuticals among the essential drugs to order. In this scenario, one of the first pieces of striking data collected during the baseline study was the practically nonexistent clinical care for severe mental illness (such as schizophrenia and bipolar disorder). The regional records showed an average of 16 consultations per year for 450,000 inhabitants, and that each year two people were admitted to the district hospital which has 108 beds. These numbers are far below what would be expected given the usual prevalence of severe mental disorders. Because there are no known indigenous healing structures for people with severe mental disorder, some thought that either there were no psychotic patients in Huancavelica, or they had been brought to other regions by their relatives, or to one of the big psychiatric hospitals in the capital Lima. It was equally surprising that there were no survivors of political violence receiving care, given the extreme severity of the problem, and despite there officially being a specific programme in place for survivor mental health recovery.

Huancavelica: a mental health care project after the earthquake

Médicos del Mundo first intervened in the Huancavelica region immediately following the earthquake of August 2007 (Rivera et al., 2008). Fewer fatalities were recorded in this region than in the coastal area, but it suffered a great deal of material damage. For more than a week, there was severe shortage of food supplies and many communities remained isolated, with no emergency support at all. The suffering of the population was aggravated not only due to the fact that this is Peru's poorest region, but also because it has been one of the most affected by the political violence during the years 1980–2000.

During this post earthquake phase, Médicos del Mundo focused its intervention on reconstructing eight health care facilities (*'centros de salud'*) and identified the need to support the small, local mental health team working in the emergency. An MDM team supported the professionals, and while working with

them it was discovered that no mental health care facilities were available in the region. The regional authorities were concerned as a result, therefore, the occurrence of earthquake helped to add mental health care as a priority to the health agenda. MDM organised an initial participatory assessment with social organisations, institutions and professionals. The aim of this was to introduce the idea of a joint effort to review the situation of mental health care in the region, and to draw up initial ideas on what kind of a regional mental health system could encompass all the main stakeholders involved in the health and social sector in the region. It was a strategic moment, as at the same time, the Peruvian government was implementing an extensive decentralisation policy and gradually transferring control (and budgets) for health care to the regions. Two three-day seminars were developed, jointly led by MDM and the head of the mental health unit of the local Health Directorate. The plan of action was then negotiated with the health authorities to ensure technical, administrative and political support to the process. In November 2008, one year after the earthquake, a collaboration agreement was signed between MDM and the regional government of Huancavelica, the Regional Health Directorate and the District Hospital, with the backing of the Ministry of Health, and the Pan American Health Organisation (PAHO). This signalled the start of a project of redesign and improvement of mental health care within the framework of strengthening the structure of primary health care services. Between June and September 2009, baseline studies were conducted on: (a) lay perceptions of mental health and priorities (15 focus groups in different areas of the region); (b) statistics of use of services; and (c) perceived needs and proposed solutions, especially those of professionals working in remote rural areas. It was discovered that neither the population, nor the professionals, could clearly identify mental health problems. The priorities were domestic violence, linked to alcohol abuse, the abandonment of old people (some of them literally dying of hunger), and conflicts and lack of solidarity attributed to the war. Health professionals could identify somatic and anxious disorders, but they did not consider depression or schizophrenia a problem worth mentioning. The statistical data also showed that there were apparently no cases demanding attention, and therefore it was not considered a priority in policy planning by local stakeholders. The project did not start until January 2010, due to difficulties in finding donors. Funding has always been short term and unstable, which has had a negative impact on the dynamics and feasibility of substantial elements of the work. Even so, the project focused on the creation of a mental health care system in an integrated and participatory way, under the coordination of the Regional Health Directorate, and with the collaboration of various levels of local health workers.

Project model

During the acute phase of the emergency

The initial focus of the MDM approach systematically avoids individual or group clinical intervention with survivors based on the idea of trauma, and instead favours community mobilisation. This allows the population to regain control over their lives as soon as possible, and to be actors in their own process. To that effect, MDM-Spain has found, since 2007, that the *IASC guidelines* (IASC, 2007) are a useful framework for reference that is in line with the strategic outlines traditionally developed by the organisation. MDM aims to: (1) support

inter-institutional coordination mechanisms (including local authorities, where the political and human rights background allows); (2) act through reinforcing community response, and strengthen collective resilience through community mobilisation and participatory tools appropriate and adapted to the political context, capacities and culture; and (3) intervene by connecting, from the first day, the emergency with the subsequent process of reconstruction, helping people to work through their own vulnerability capacity analysis. When MDM chooses to go to an emergency, this is usually associated with an initial commitment to remain for 6 to 12 months, to be extended if there is the possibility of supporting processes for consolidating public mental health care service systems.

From the acute phase to transformation

In general, in abandoned areas, disasters can create real opportunities for change. It is important to bear in mind, in the initial assessment, how to unite the crisis to the post crisis, in one shared, common framework. What happens in many situations, when most nongovernmental organisations (NGOs) are purely focused on emergencies, they leave, and then people and communities are generally forgotten and end up in a more vulnerable position than before. This requires an intervention during the emergency that does not replace nor compete with the public health systems in mental health care, but tries to see the emergency as an opportunity to reinforce and complement them on a temporary basis, and to set a framework for further development. In many situations, this is also an opportunity to introduce new ideas and proposals regarding integrated clinical and community care that goes far beyond what the state usually provides.

After an initial assessment, some initial ideas can be drafted with local authorities and civil society. This also entails preparatory work, whereby certain agreements are signed for the transfer of any new services to the public health network, in order to ensure as much as possible, future sustainability once the NGO leaves. Consequently, the services developed will be in tune with the design of the overall health strategy and the National Mental Health Plan. In some contexts, this will already exist prior to the crisis, and in others the World Health Organisation (WHO) or PAHO will be in the process of collaborating an agreement with the Ministry of Health (MoH). In other cases, no such groundwork will exist, and therefore it will be essential to recommend that this work on an integrated plan be carried out.

For this reason, MDM collaborates with other national and international organisations and authorities, to help create the conditions for executing a national plan. This is done in collaboration with the health authorities and public institutions, and social and human rights organisations working in mental health and psychosocial fields. It also includes the general population, particularly service users, as they are usually excluded from the process. This is usually done using a bottom-up strategy, involving community leaders, to define what mental health is, and what the priorities should be in a policy plan. This works simultaneously with a top-down approach that collaborates sensibilities and joint efforts at all levels of the health care system. In those contexts, where national health plans do not allow for a comprehensive approach (e.g. progressive reform of psychiatric hospitals, systems integrated with the basic health service network, etc.) it is hoped that working within a network will promote a review of processes with

authorities and actors involved. In this way, we move in the long term towards models of comprehensive psychosocial and community services in the field of mental health. The objective is therefore to be able to jointly assess the system of mental health services in the country or region that is suffering the crisis, working in collaboration with the Ministry of Health, United Nations agencies, major mental health focused NGOs involved in the crisis, and the actual people affected.

Helping people to review a current mental health system, and what would they like it to become is not enough without also having a commitment to develop substantial parts of it. One possibility is to look for different NGOs, who can assume different parts of the intervention. However, it is usually better for each NGO to assume the development of a full system within a region, including all the specific difficulties and shortages. This includes systems of exchange and coordination that allow for mutual reflection and education through the implementation of the plan in each area. Each context requires specific and careful analysis tailored to local circumstances.

For example, it is not possible to compare the factors at play in a country like Sri Lanka, with those in Palestine, or Haiti. In Sri Lanka, the following conditions exist: mid income, political willingness to implement a process of reform, minimal number of professionals, and a five-year plan developed as collaboration between the government and the WHO. Whereas in Palestine the situation is: low income, high number of professionals, many political actors with different political attitudes in regard to the authorities, and a five-year plan developed with the WHO. While in Haiti it is: very low income, complete lack of professionals, predominantly private medicine or provided by charities, no plan, and almost complete absence of resources to fund any proposals (Figure 2).

From planning to action in Huancavelica: several areas of work that were addressed simultaneously

- Peru has a National Mental Health Plan, but is far from responding to the specific needs of the Huancavelica Region. Developing the Regional Mental Plan through an extensive participatory process driven by MDM and the Regional Health authorities was one of the main objectives

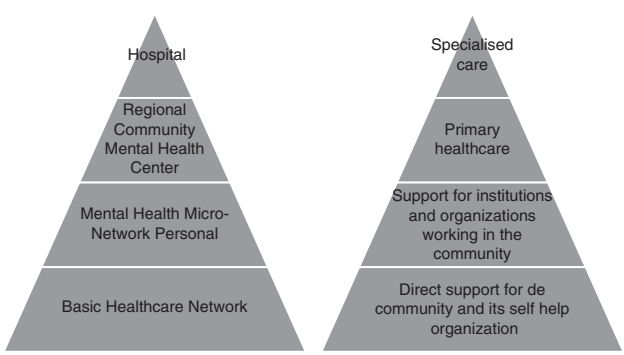

Figure 2: Proposed structures and levels of care.
Source: Independently produced.

of this project. The final document is a comprehensive five year plan, with six different areas, and 22 objectives ordered by priorities and levels of responsibility, of each stakeholder in the health care sector. At the time of writing this paper, the final drafts were under discussion and refinement.

- Redesigning, extending and equipping the Community Mental Health Centre (CMHC) run by Huancavelica District Hospital. This was an old building, attached to the hospital that had to be rebuilt. It is now a refurbished two floor building that includes three outpatient consultation rooms for adults and children, a room for training workshops and group therapy, a small addiction unit in the basement, and a kitchen. Additionally, there are two small rooms for relatives of psychotic patients admitted to the hospital who must travel long distances, and for community health workers staying in town. The CMHC is designed to meet the clinical demand in town, while creating a regional centre of technical reference with the ability to formally train, supervise and enhance the performance of mental health care workers and the health teams scattered across the region.
- In Huancavelica, the health system does not attend people with serious mental disorders. Additionally, although victims of political violence are considered a priority, they are not reached by the system, as far as there are no proactive activities to the rural areas where most of them live. Also, for many cultural and community reasons, people affected will not go to the health centre to consult for their mental health symptoms. A pilot action research has been completed for the detection of the hidden population of patients with unmet needs. There was the hypothesis that there was a large, hidden demand for both populations, and the challenge was to uncover it with the few resources available. So, three areas were chosen for a pilot action research. This means that the team was doing a *research* on prevalence of mental disorders, but at the same time this was done hand-in-hand with the community. The patients detected were enrolled in a case management programme with the nearest health centre (*action).* Theoretical research was applied to action, involving those supposedly the subject of the research. This research has been done in three pilot areas. Two groups of four local health workers, using a standard protocol, have gone community by community, talking to community leaders, and religious and social authorities and neighbours. The team approached patients, relatives and neighbours in a nonintrusive way. It should be pointed out that in the first week of working with informants from just one of the 27 micro-networks (the base administrative structure of the Peruvian health system) around the region, 13 severely psychotic patients were found in conditions of semi-abandonment, or confined to the home. This is more than the number of patients seen in the last five years in the District Hospital. At the end of the first two months, 60 severely psychotic patients, most of them already diagnosed at some point in their lives, were left untreated, and with no access to proper care. This was an unexpected and surprising result for the local team and an important revelation. A second action research, following a similar methodology, explored the needs of survivors of political violence with severe psychological problems. The team asked, in each community, for people officially

recognised as a survivor by the TCR. They then searched for other survivors, using a snowball sampling methodology. The team conducted individual interviews, not focused on trauma or symptoms, but on overall health (including mental health), life in the community, needs and expectations. In the context of extreme poverty, such as in Huancavelica, the results showed that the survivors were worried because they had not received economic reparation, in spite of all the intervening years. They asked for psychological support, but in truth were much more interested in being helped to get their small funds paid. These two populations, those with mental illness and survivors of political violence, will become initial priorities of future training programmes for psychologists within the micro-networks. The next action researches considered for the immediate future will include suicide and alcoholism. This is because alcoholism is extremely common in the region, and the basis of sexual abuse and domestic violence. These two topics will be based on a completely different methodology, more grounded in qualitative and anthropological methodologies. The health authorities are designing an information system that will specifically collect data for building a system of continuity of care for severe mental disorders.

- The training of health personnel has begun slowly in a pilot micro-network (Angaraes, 60,000 inhabitants). It is based on bringing professionals from other regions that can train in clinical and community care, by means of supervising complex cases, and training based on actual situations brought in through participants from their daily work. The training also includes working with communities severely affected by violence to do self-assessments, using action research principles. The aim is to generate processes of collective strengthening in communities affected by poverty and violence. It is hoped that the psychologists will be able to create self-managing community psychosocial processes.
- The programme includes support for associations of survivors of political violence and the Regional and Provincial Reparations committees, in order to strengthen human rights initiatives. There will also be exhumations of mass graves in the region in the near future. The local mental health workers will receive training in the International Standards for Psychosocial Support in the Search for the Disappeared (Navarro-García, Pérez-Sales, & Fernández-Liria, 2010).

Future steps

Overall, the future is uncertain. Despite the political agreements that have been signed and the consensus regarding the mental health care plans, elections can bring radical changes. This was the case in Huancavelica in 2010, and in 2011. The new authorities promised to respect agreements and provide full support to the process. However, despite these promises, the Peruvian government has introduced new budgetary management systems based on Results Based Financing (RBF, a financial strategy that attempts to provide estimates in terms of concrete results). This has brought chaos to mental health planning. RBF attempts to assign resources based on patients attended, severity of diagnosis, average length of each intervention and so on. These sorts of estimates are almost impossible at the present time as there are no structured, basic mental health services. The criticisms and confusion

resulting from this has now created a question on the whole model, and the future of budgetary assignments from Lima remains uncertain. This kind of policy planning, perhaps appropriate for other fields of medicine like surgery or orthopaedics, is more geared towards closed clinical diagnoses and expected expenses that can be attributed to patient and diagnosis are difficult to fit into the psychosocial context. This kind of budget by results carries the risk of limiting the effects of the reforms achieved thus far, unless there is more flexibility. For this reason, it is a key for the future to maintain the participatory nature of all the process until now. This will ensure that, beyond the transfer agreements signed by the authorities, the situation cannot easily revert because there are lasting changes in team structures and perspectives for their objectives and work. In this way, a broad base of social and citizen participation, which will support the changes, will be created.

Lessons and suggestions

Many lessons have been learned in these three years since the earthquake, and these are discussed below.

1. *The importance of prioritising the strengthening of mental health services within the public health system.* Peru is making a significant effort to develop free healthcare programmes and a mental health care programme must have a place besides the more traditional health objectives of prevention of maternal mortality, vaccinations, and child nutrition. The situation generated by the earthquake helped to find receptive and favourable political authorities. Although, for the moment, these programmes are limited to illnesses and disorders defined in the national PEAS (*Plan Esencial de Aseguramiento en Salud*, or Essential Health Insurance Plan), which does not include mental health. However, the majority of trained health workers in the centres and networks are keen to expand their knowledge and skills in this area, and to push for its inclusion in the PEAS in the future.
2. *The value of designing intervention plans locally through participatory processes involving all actors.* The different regions of Peru vary enormously from one to the next, and therefore the National Mental Health Plan and central government guidelines cannot be applied directly, without recognising the particular characteristics of each area and the existence of local institutions and actors. At the same time, the local perspective is enriched by, and benefits from, being integrated into the national and international context, particularly in terms of the guidance and support offered by PAHO.
3. *One of Huancavelica's particular challenges is its extensive and extreme geography, problematic means of communication and dispersed population.* For this reason, innovative systems are required. The proposed plan would create a network of small units, with little or no dependence on central structures, particularly the hospital, and within which there can be a regional centre acting more as a technical and training consultant, than a clinical reference point. The organisation cannot work as a pyramid of services of increasing complexity and systems of screening and referral among levels. It must be closer to a horizontal multinodal system.
4. *The survivors of political violence appear in all political declarations by authorities, but are in fact excluded from the health agenda,*

despite the existence of specific resources and budgets from the national reparations programme. This can be explained by a number of factors, discussed below. 1) On the one hand, the very nature of the damage of political violence, which includes fear, lack of confidence, polarisation and isolation, dictates that the programmes must be proactive. There is not much sense in waiting for the survivors to come to some kind of specialised facility. 2) In addition, there is a lack of specific training for health professionals, aggravated by the constant rotation of staff that prevents the personnel from establishing bonds of confidence with the survivors. It is necessary to put a lot of emphasis on rectifying this situation. Health professionals are not trained to be proactive in their work, but tend to wait for patients to come. 3) The government is now offering economic compensation far below what was promised three years ago, before elections, thus limiting access to health and mental health care, and increasing distrust towards any one working in the public sector.

5. *The method of detecting severe mental illness by proactively entering communities, and using key informants and snowball sampling methods, proved to be an extraordinarily effective strategy*. The authors have advanced some data here. The process and detailed methodology and epidemiological findings will be published elsewhere. However, such an easy, cheap and direct intervention has proven to be more cost efficient, feasible and respectful to patients and communities than the more sophisticated methods of two-stage screening using door-to-door, semi-structured interviews. Although we cannot detect all cases, it is possible to make an initial case register in a short time without using extra human resources, and begin to change stigma and marginalisation by spreading the word that there is treatment for severe mental illness, and that the health care system can help in providing it.

Conclusion

The authors have presented an outline of the implementation and progress of the Regional Mental Health Plan in Huancavelica (Peru), in order to demonstrate that an emergency intervention, following the earthquake that devastated the centre of Peru in 2007, can become a catalyst for change. NGOs should be able to work, not only based on an immediate needs assessment, but also by keeping an eye on structural vulnerabilities. It is important to have an historical long term view that understands that there is a past of poverty, war and violence and that there must be a future. It is possible to create a development project in a short time, taking advantage of the great amount of funds that emergencies usually raise. The emergency funds, lasting approximately a year and half, allowed the reconstruction of part of the physical infrastructures that were damaged, and built new ones. Instead of substituting or competing with existing structures, the initial six months of reconstruction enabled an analysis of the previous mental health care system, and allowed for designing alternatives to reinforce it, in collaboration with technical staff and local authorities. Importantly, the project was designed as a participatory process that departed from the perception of needs by the survivors, and agreements with authorities. The crisis was the opportunity for change.

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