

FOCUS: GLOBAL HEALTH AND DEVELOPMENT

The Unknown Role of Mental Health in Global Development

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In this paper, the author contrasts the substantial impact of mental health problems on global disability with the limited attention and resources these problems receive. The author discusses possible reasons for the disparity: Compared to physical disorders, mental health problems are considered less important, perhaps due to lower priority of disorders that primarily cause dysfunction rather than mortality, and skepticism that mental disorders are treatable in low-resource countries. He argues that achieving improved global health and development requires addressing problems causing disability, particularly mental health problems among populations in which the common mental disorders are frequent due to deprivation, war, and disasters. The author contends that services addressing the common mental disorders could be made widely and relatively cheaply accessible if provided by non-professional workers at the community level.

INTRODUCTION

The first publication of the *Global Burden of Disease* (GBD†) by Murray and Lopez in 1996 [1] carried a surprising message: that mental disorders were among the major causes of disability in high-, middle-, and low-income countries. The authors of the GBD estimated that depression alone

caused more disability than either nutritional problems or HIV, which were then prime foci of U.S. health-related international programs. Prior to the publication of the GBD, mental health problems were not even “on the radar” of the then field of international health.

Since then, the World Health Organization (WHO) has been steadily moving

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†Abbreviations: DSM, Diagnostic and Statistical Manual; CMD, Common Mental Disorders; GBD, Global Burden of Disease; PTSD, Post-traumatic Stress Disorder; WHO, World Health Organization.

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mental health problems up the global ranking of causes of disability. Currently, WHO rates depression as the single greatest cause of disability worldwide, affecting at least 350 million people [2]. The disability associated with depression has been found equivalent to that caused by blindness or paraplegia, whereas disability due to active psychosis (as in schizophrenia) has been estimated as somewhere between paraplegia and quadriplegia [3]. The functional effects of mental illness are also more wide-ranging in scope than most physical illnesses, affecting not only physical functioning but also profoundly affecting cognitive, emotional, and social functioning. Those affected lose not only their ability to work, but also to think, plan, cooperate with others or provide or receive social and emotional support.

While this has caused some buzz in the global health field, and mental health now garners more attention than previously, the amount and relative importance placed on mental health is nowhere near the level that these rankings would suggest is appropriate. Even recent estimates of the direct role of mental illness as a cause of mortality — there are 800,000 suicides per year globally [4] — have not had much of an impact. In this paper, the author reflects on why this may be so, based on 15 years of research and program development in global mental health. He explores possible approaches to addressing this disparity and the potential role of mental health research and services in promoting global health and development.

MENTAL HEALTH REMAINS A LOW PRIORITY

If mental health problems are major causes of disability globally, then why does mental health remain a low priority? One cause may be that mental health suffers from an image problem. In all societies of which the author is aware, mental illness carries a stigma. This attitude is so widespread that one can only conclude that stigmatizing those with mental disorders is a human rather than

culturally defined response, although culture does appear to influence its severity and response. One way to understand stigma is as a human response to perceived threat. We stigmatize not only enemies but also those who threaten us without meaning to, such as persons with infectious diseases or those with mental illness who cannot be “trusted” to behave rationally or predictably. When a problem generates stigma rather than sympathy, it is more difficult to summon interest and resources to address it. Part of the problem with mental health is that all disorders tend to be lumped together. Persons with anxiety and severe schizophrenia both have a mental disorder and may be regarded in the same way, even though threatening or irrational behavior is not a feature of anxiety (or depression or PTSD).

Whatever the cause, mental health has always been a secondary health consideration even in high-income countries. National health policies in most countries clearly subordinate it to physical health. Here in the United States, health insurance companies historically have provided less (or no) mental health service coverage, and government-supported mental health services receive a small fraction of the resources allocated to physical health services [5,6].

In middle- and low-income countries, the subordination of mental health to physical health has been (and in most cases remains) more extreme. Mental health services are frequently unavailable outside cities or major hospitals. Forty percent of countries have no national mental health policy, which is actually an improvement over the situation just 10 years ago [7]. All this reflects a general attitude that mental health issues are much less important than physical health. The author can still remember being introduced to the Dean of a school of public health in the early 1990s — a person with a long career in international health. When asked by the Dean what the author’s interests were and responding that they included mental health in Angola, the Dean responded, “I think people in Angola have a lot more important problems than mental health.”

In 2014, this attitude persists among many of the service organizations, governments, and donors that the author encounters. This is understandable when considering the many physical health problems that are both prevalent and cause severe illness and death, diseases like HIV, malaria, tuberculosis, and injuries. However, opinions that mental health is less important frequently translate into *actions* (or more commonly, lack of actions) that suggest that mental health is of *little or no* importance. The result is not just fewer resources and attention, but little or none. The author believes that this is a mistake. In this article, he discusses some of the reasons why we should consider putting significant resources into mental health in all countries, even those with limited resources and severely affected by physical diseases.

THE NATURE OF MENTAL DISORDER

There is no universally agreed-upon definition of what constitutes a mental disorder. This section draws heavily on the 5th edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-V), an internationally used compendium of mental disorder diagnoses, which provides the following definition:

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior, that reflect a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” [8].

Some mental disorders have a strong genetic element. This is particularly true of the psychoses, such as schizophrenia. They tend to cause severe dysfunction and routinely require drug treatment. These disorders are also uncommon, normally affecting no more than a small percentage of the population. Therefore, while their impact on individuals and families are large, their overall public health and global development impact is relatively small.

A second group of mental health problems is largely conditioned by events and the environment, even though some are also familial. These are of great interest in global development because the extremes of events and environment in some low-income countries can cause high prevalence rates. Of these, the most significant in terms of frequency and severity are depression, anxiety, and post-traumatic stress disorder (PTSD). These are collectively referred to as the common mental disorders (CMDs). Depression is usually associated with loss, such as loss of close family or friends, home, income, or culture. Symptoms are similar to bereavement except that there is no recovery with time. The main symptoms are deep sadness or despair, a general loss of interest in self and the world, and a pervasive difficulty in functioning. Anxiety disorders refer to excessive or excessively persistent worry, nervousness, fear, and heightened physiological arousal in response to perceived threats or challenges. PTSD is the result of exposure to a violent and threatening event. While globally much less common than the other two, the latter is of particular concern after wars and disasters. Symptoms include a hyper-alert state that causes severe distress. It is as if the person’s mind is permanently guarding against recurrence of the violent event, even if the person knows that such an event can no longer occur.

One way to think of all three conditions is as temporary coping or adjustment responses by the brain to environmental challenges which, if the response becomes permanent, become problems in themselves. For example, depression could be considered as the brain’s response to losses of those things that form an important part of how a person copes with the world. The loss of a spouse, for example, entails reinvention of how a person meets the challenges of everyday life now that an important means for doing so has been removed. Withdrawal and reflection on loss is part of normal bereavement, which ends when the person has formed new coping mechanisms that replace the loss. Failure to make the adjustment leaves the person in a permanent state of

withdrawal. Anxiety can be considered anticipation of future threats based on past experiences. PTSD symptoms can be considered normal reactions to danger that become pathological when they fail to resolve the removal of the original threat. Persons with any of these problems can be very difficult to live with. They may be incapacitated, contributing little to the family but exhausting in their demands on the family's time, resources, and emotional energy and frequently causing disharmony. In many cultures, those affected and their families suffer the additional burden of the stigma associated with mental illness that affects how the family is treated by the community [9]. The author and colleagues have found that the effect on ability to marry can be a major concern. For example, in recent years, we have conducted research in northern (Kurdistan) and southern (Arab) Iraq and found that the stigma associated with mental illness can indeed extend to the entire family [10]. Anyone who has a close relative with mental illness has difficulty finding a marriage partner, based on the belief that mental illness runs in families. This causes both individuals and their families to hide mental illness and resist treatment because of risk of exposure.

Associated with the common mental disorders are "psychosocial problems." The term is not well defined. In the author's experience, it refers to non-pathological situational problems such as disputes, family separation, or an uncertain future, and to the resulting distress. Finally, there are problems of substance abuse. These refer to the excessive use of substances to the extent that it affects a person's ability to function. Substance abuse, particularly of alcohol, has a genetic element but is also related to stress [8] as a means of coping with adverse circumstances. Therefore, psychosocial problems and substance abuse commonly occur with other mental health problems.

Perceptions of Mental Disorders in Low- and Middle-Income Countries

Prior to the late 1960s, mental illness was considered an important issue only in Western countries or among white popula-

tions [11,12]. The author's experience in Africa and Asia during the 1980-1990s was that Western aid workers believed that local people were not subject to these illnesses or, if they were, that they were minor issues. This may be, because, unlike physical illness, the manifestations of mental illness can be mistaken by outsiders for other problems. Anthropologists who studied local cultures in these countries were similarly untrained in psychiatry, and little was known about how psychiatric symptoms vary across populations. Recognition by outsiders was probably not helped by the associated stigma, which causes people to hide mental illness.

When mental health was first being seriously considered a global problem, after the publication of the *Global Burden of Disease* in 1996, one of the first issues raised was whether people from different cultures are subject to the common mental disorders or, if so, whether they experience them in ways that are vary significantly between cultures. Either finding would suggest that mental health is not really a priority global health issue — the former because mental health problems were not frequent and the latter because it would be difficult to develop methods to identify and deal with disorders across cultures. PTSD has been a particular focus of debate as to whether it exists outside Western countries. Some have argued that Western psychiatry is seeking to "medicalize" normal reactions to stress and loss and therefore promote treatments that are wasteful, inappropriate, and ineffective [13].

When the author first entered this field in 1999, this debate was at its height. Although studies existed that found depression, anxiety, and PTSD among various cultures, many were based on standard instruments developed in Western countries without adaptation. These highly structured instruments asked about the presence of each of the standard symptoms (and only these symptoms) in a closed format. Because these instruments consist of leading questions, respondents' answers did not constitute proof that the disorders existed lo-

cally, since closed leading questions can be answered even if the respondent does not understand them.

Since the 1990s, there has been a gradual diffusion of qualitative research skills among psychologist researchers and the application of these skills to cross-cultural psychological research. The resulting research, based on open-ended, non-leading interviewing, has increasingly demonstrated that although there are some symptom variations, many mental disorders occur across many diverse cultures and situations [14,15]. The common mental disorders are more frequent in those countries where loss, threat, and violence are also frequent due to deprivation, war, and other disasters [16]. This strongly suggests that these disorders are human rather than cultural problems and that people around the world develop these disorders for the same reasons.

In the last few decades, ethnographic and qualitative research on mental health has tended to focus on populations affected by disasters and violence. The intent of this research has been to remove leading questionnaires from the interview process. When not responding to leading questions, respondents in most of the cultures studied have provided descriptions of problems that are similar to the three common mental disorders. The author and colleagues have conducted this type of research among populations affected by war or disaster in Africa, the Middle East, Eastern Europe, North and South America, South East Asia, and the Caribbean [10,17-24]. In those populations studied so far, at least one or more of the three common mental disorders has been identified. Sometimes they appear to occur alone or separately, but more often they occur in combination, probably because the populations that have been studied in low-resource countries often experience causes related to several or all three categories of loss, threat, and violence. For example, here are two mental health problems described by people in Uganda who had been severely affected by HIV, resulting in both loss of close family members and economic distress [24]. Both disorders were

said to be common and frequently occur together:

Yo'kwekyawa: feeling lonely; no interest in things; worrying too much about things; feeling hopeless about the future; hating the world; thought of killing self; irritability; bad, criminal or reckless behavior; feeling sad; feeling worthless; not responding when greeted/withdrawn; crying easily; poor appetite; feelings of severe suffering and pain.

Okwekubagiza: feeling sad; feeling lonely; worrying too much about things; feeling worthless; low energy; feeling slowed down; crying easily; feeling fidgety; feeling no interest in things; feeling everything is an effort; irritability; unappreciative of assistance; thoughts of killing self.

Those symptoms marked by the dagger (hating the world, bad/criminal/reckless behavior, lack of appreciation of assistance) are the only ones not explicitly part of the Western clinical descriptions of anxiety and depression. Results of the other qualitative studies among diverse populations show similar findings with respect to syndromes that reflect separate or combined descriptions of depression, anxiety, and PTSD. While there are some variations in symptoms and how they are described, the basic presentations are similar across cultures, suggesting that these are human responses rather than cultural phenomena.

THE IMPACT OF MENTAL DISORDERS IN LOW-INCOME COUNTRIES

Despite suicide and indirect effects on mortality, mental disorders are appropriately associated with morbidity and disability. When considering social and economic development, it is a mistake to regard major causes of disability as less important than the causes of mortality. In economic and so-

cial terms, morbidity could be considered more important than mortality in that it is much more common. Also, although those who have died cease to contribute to the good of their family and community, they also cease to use resources. Contrast this with persons whose morbidity results in severe dysfunction. Not only is the person's contribution lost or greatly reduced, but the family and community must now expend additional resources to take care of the person. Where health programs focus on mortality without equal concern for morbidity, the result may be an increased prevalence of disability, which may actually contribute to economic decline [25].

For common mental health problems such as depression, resulting morbidity and reduced function can last for years or decades and is more wide ranging than many other causes of morbidity — affecting not only physical function but also ability to think, feel, and maintain relationships. Morbidity due to mental health problems can also be one of the longer lasting effects of mortality. In 2000, the author conducted research in Uganda among a population that had in the 1980s suffered high rates of mortality due to HIV [26]. The international NGO working in the area was providing resources, but the population seemed listless and disinterested. The research found that many people showed significant depression and anxiety symptoms resulting from lost family members, with almost a fifth having symptoms consistent with clinical depression [27]. Similar studies in other cultures among populations affected by loss have had similar findings [16].

STRATEGIES FOR MENTAL HEALTH PROGRAMMING FOR GLOBAL DEVELOPMENT

These findings from the last few decades have two important implications for global health and development. First, not only are the common mental disorders common across cultures, but they are likely to be more common in low-resource countries because the environmental causes of loss,

stress, and violence are also common. Second, if these disorders are similar in terms of symptoms and causes to disorders in high-income countries, then there is a good chance that they are also amenable to the same treatments found to be effective in high income countries. The similarities are clearly strong enough to at least support the adaptation and testing of these interventions as means for reducing mental health related disability.

From research originally done in high-income countries, we already know that many mental health disorders are highly treatable. In high-income countries, treatment is expensive and most frequently consists of drug therapy by a psychiatrist. However, this does not reflect the full range of treatment options. For many illnesses, including PTSD, depression, and anxiety disorders, non-drug interventions have been found to be effective, yet are not commonly used. This may be because psychiatrists are mainly trained in drug therapy. Whatever the reason, drug therapy by a psychiatrist is the first line of treatment in many high-income countries, leading to the misconception that drug treatment by psychiatrists or other professional mental health workers is the preferred option. Among some advocates for global mental health, the question has therefore arisen as to how to provide widespread access to mental health professionals in low- and middle-income countries. Given the low level of resources allocated to mental health, there does not appear to be an answer.

Advocates for access to physical health services faced the same challenge in the 1960s and 1970s: how to provide widespread access to doctors for the world's population, including low- and middle-income countries. They eventually decided that this approach was not feasible and that true access would require training large numbers of primary health care workers to take on much of the doctor's role at the community level [28]. The author suggests that the same approach is needed to achieve widespread access to effective mental health services, to find effective and cross-culturally accept-

able interventions that do not require psychiatrists or clinical psychologists and put them in the hands of community-based “community mental health workers.”

For the last 15 years, the author and colleagues in many countries have been conducting research and working with service providers to determine which interventions could be provided at the community level. The focus has been on non-drug interventions for several reasons: the relatively long duration of most drug regimens for mental health problems; the low prioritization of mental health that makes it unlikely that governments or service providers would financially sustain drug treatment; the expertise required to monitor drug therapy; the potential for toxicity; and, finally, the frequent resistance in many cultures to taking drugs long term to control symptoms rather than cure disease. For the common mental disorders, there was already evidence in high-income countries for the effectiveness of non-drug interventions based on psychotherapy. The question now is whether community-based workers from diverse cultures can provide psychotherapy correctly, whether people from those same cultures would accept it, and whether the therapy would be effective. At the time of writing, randomized controlled trials have been published among cultures as diverse as Uganda, Pakistan, Democratic Republic of Congo, and Chile [29-32], and further trials are under way in other countries including Thailand, Colombia, and Iraq. In all these trials, the providers have been non-professionals who received training and supervision before and during the trials. In all trials published so far, providers were able to learn how to provide treatments appropriately, and most trials have shown psychotherapy to be highly effective. The most widely effective interventions have been those based on cognitive behavioral therapy originally developed in Western countries. Despite its Western origins, in each of the published trials, the research teams and local non-professional workers were able to adapt CBT or its components so that it was acceptable to many local people.

These studies in low- and middle-income countries have demonstrated that the common mental disorders responsible for the greatest global morbidity are treatable without drugs. The adaptation of interventions that can treat prevalent, severe, and persisting causes of morbidity without drugs or medical equipment should enhance their cost effectiveness and sustainability. These trials have opened the door to providing services at the community level, potentially making them widely accessible globally.

In recent years, the author and colleagues have begun to explore new uses for psychotherapy in the hands of community workers. This is based on the observation that the common mental disorders begin as normal reactions to environmental challenges that have become pathological through persistence beyond the normal grieving period and/or after the removal of stress or threat. In other words, the same symptoms occur in persons with pathology as in “normal” persons during bereavement, stress, or threat. This raises the question as to whether the underlying brain processes are the same and therefore whether persons in challenging circumstances could be helped by psychotherapy, either to resolve symptoms more quickly or to assist persons with symptoms that are not severe enough to be classified as pathology but are still distressing. Used in these contexts, psychotherapeutic methods can be seen as life skills for persons in poor and challenging environments. For example, the author and colleagues are currently conducting a study providing counseling and psychotherapy to orphans and other vulnerable children in Zambia regardless of mental disorders. The intent is to determine if using these interventions as life skills training can assist children, regardless of the presence of mental disorder, to make better decisions about their current situation and their future, such as avoiding risk-taking behaviors.

CONCLUSIONS AND OUTLOOK

Comedian Emo Philips has been quoted as saying, “I used to think that the brain was

the most wonderful organ in my body. Then I realized who was telling me this.” We all run the same danger of over-emphasizing the importance of our own field and unconsciously (or not) promoting our own interests. There is certainly that danger in writing about one’s own field of global mental health. Whether or not global mental health is as important a field as physical health or the other fields necessary for global development is not a useful question. However, the author does believe that the body of this paper supports the need to give more resources and attention to mental health than the small amounts it currently receives, based on the contribution that it can make to physical well-being and functioning globally, particularly among those affected by deprivation, violence, and stress as so many are in low-income countries. In the last 100 years, science in high-income countries has learned useful things about how the brain works, and in the last few decades, workers from high- and low-income countries have begun to learn how to apply these lessons across cultures. While knowledge of how to deal with mental health problems lags behind most of physical health, it is clear that mental health problems, particularly the common mental disorders, are major but treatable causes of morbidity. They are amenable to treatments that can be made widely available at the community level by training and supporting local providers. And finally, such treatments can be effective in significantly reducing suffering and improving function not only for those affected, but also their families and their communities.

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