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Implementing the *Mental Health Gap Action Programme* in Cox's Bazar, Bangladesh

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Abstract

In response to the overwhelming need for mental health and psychosocial support as a result of the humanitarian crisis in Cox's Bazar, the Directorate General of Health Services, Ministry of Health and Family Welfare Bangladesh, in collaboration with the World Health Organization, the National Institute of Mental Health and the National Institute of Neurosciences, implemented the World Health Organization's Mental Health Gap Action Programme in November 2017. Over the course of two trainings and supervision visits, general physicians, counsellors and other health professionals from both government facilities and nongovernmental organisations, working with both the host and Rohingya populations, have improved their capacity to assess and manage priority mental, neurological and substance use conditions using the Mental Health Gap Action Programme intervention guidelines. After the first training, over 75% of participants reported feeling confident to apply their learning to their work. Participants receiving the supervision visit valued this follow-up modality and demonstrated a high level of competency during an observed consultation. This was the first instance of the Mental Health Gap Action Programme implementation by the government of Bangladesh following a humanitarian crisis. Our findings suggest that trainees are providing better quality services to assess and manage mental health conditions and that mental health is being integrated into primary health care service delivery.

Keywords: Bangladesh, Cox's Bazar, implementation, mental health, *Mental Health Gap Action Programme*, refugee, Rohingya

INTRODUCTION

Bangladesh is currently facing a humanitarian crisis in Cox's Bazar, a district in the south eastern area of the country where many Rohingya refugees reside. Within four months from the end of August 2017, over 700,000 Rohingya refugees (including more than 380,000 children) arrived in Cox's Bazar, fleeing violence in Myanmar. As of August 2019, there were an estimated 912,485 Rohingya refugees in the district (WHO, 2019). The need for mental health and psychosocial support (MHPSS) was, and remains, high within this context.

Mental health burden and professional capacity

Mental, neurological and substance use (MNS) conditions account for an estimated 9.5% of disability-adjusted life years and 28.4% of years lived with disability globally (WHO, 2018a). In Bangladesh, over six million people experience depressive disorders and almost seven million people have anxiety disorders (WHO, 2017b). There are

6.7 deaths from suicide for every 100,000 females and 5.5 deaths from suicide for every 100,000 males (WHO, 2018c). Among students aged 13–17 years in Bangladesh, 4% of boys and 6% of girls consider attempting suicide (WHO, 2017c). A systematic review of studies on mental health conditions in Bangladesh reported that the prevalence ranged from 6.5% to 31.0% among adults and from 13.4% to 22.9% among children (Hossain, Ahmed, Chowdhury, Niessen, & Alam, 2014).

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In Bangladesh, there are 0.13 psychiatrists and 0.12 psychologists per 100,000 population. A total of 1,893 professionals work in mental health in the government and nongovernmental sectors (WHO, 2018c). Public health general medical services are organised and delivered through the Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare. There are two tertiary centres for mental health which also provide primary mental health care. These are the National Institute of Mental Health (NIMH) in the capital, Dhaka and Pabna Mental Hospital in Pabna district. Mental health outpatient facilities are present in 69 hospitals (public and private), whereas 56 hospitals have psychiatric units for inpatient care (WHO, 2018b).

Therefore, despite the burden of disease in Bangladesh, as in many low- and middle-income countries, the capacity of the primary health care system (including outpatient departments of district hospitals, Upazila [sub district] health complexes and community clinics) to provide mental health care is limited, and mental health conditions remain highly stigmatised. In similar contexts, the treatment gap may exceed 90% due to the scarcity and unequal distribution of services and care (WHO, 2018a). With this background, providing mental health and psychosocial care in humanitarian crises can be especially challenging, particularly as projections of mental disorders in adult populations affected by emergencies are at a twelve month prevalence of 3% to 4% for severe disorders and 15% to 20% for mild and moderate mental disorders (World Health Organization & United Nations High Commissioner for Refugees, 2012).

WHO's Mental Health Gap Action Programme

WHO's *Mental Health Gap Action Programme* (mhGAP) contributes to achieving universal health coverage by integrating mental health care into primary health care settings. The programme was launched in 2010 and is supported by several implementation tools, including the *mhGAP Intervention Guide* (2.0) (mhGAP-IG) (World Health Organization [WHO], 2010). The mhGAP-IG for MNS conditions in non-specialised health settings is a clinical decision-making tool to assist healthcare workers in primary health care settings to assess and manage priority MNS conditions, which also aims to scale-up care for people with MNS conditions (WHO, 2018a). The first version of mhGAP-IG was used in over 100 countries, translated into more than 20 languages and widely accepted by a range of stakeholders, including ministries of health, academic institutions, nongovernmental organisations (NGOs) and other philanthropic foundations and researchers (WHO, 2016a). In recognition of the specific and augmented needs for mental health care in crises and emergencies, and often limited pre-existing capacity to provide mental health care, WHO and United Nations High Commissioner for Refugees (UNHCR) also published the *mhGAP Humanitarian Intervention Guide* (HIG) in 2015 (World Health Organization & United Nations High Commissioner for Refugees, 2015).

mhGAP was first introduced in Bangladesh in 2011. The approach was implemented in response to the crisis in Cox's Bazar in 2017 by DGHS, with the support of WHO and psychiatrists from NIMH and the National Institute of Neurosciences (NINS). This field report describes the adaptation of mhGAP training guidelines, evaluation results and the practical challenges encountered in implementation.

PROJECT Background

In September 2017, technical officers from the WHO Country Office for Bangladesh and the WHO Regional Office for South-East Asia conducted a rapid assessment to better understand the complex context and identify MHPSS needs and available services in Cox's Bazar. Several agencies were providing psychosocial support services in response to the immense need. It was observed, however, that while more services for management of mental health conditions were required, there was no psychiatrist available in the government's health care system in Cox's Bazar to provide specialised support. The 2017 WHO rapid assessment report recommended providing training on mhGAP to increase capacity for mental health care provision in primary health care settings.

Adapting mhGAP intervention guides: content and tools

The first step of implementation was adapting the content of mhGAP to the context. A key factor considered was the limited time available, particularly in the initial phase of the emergency, for healthcare workers from government facilities and humanitarian organisations to attend the training, given the high patient load. The implementation team concluded that it would only be feasible to request healthcare workers to be released from their duties for a maximum of three days for training. Subsequently, the team prioritised the topics to be covered and designed the programme according to the time available. In this prioritisation, the team considered the conditions expected and reported to be more prevalent in the emergency as well as the long-term vision of building back a better national primary mental health care system to address priority mental health conditions in Bangladesh, including child and adolescent mental health. To balance these complementary goals, seven modules from mhGAP-IG (2.0) were selected: essential care and practice (ECP), depression, self-harm/suicide, child and adolescent mental and behavioural disorders, psychosis, epilepsy, support and supervision. Two modules from mhGAP-HIG, not available in 2.0, were incorporated into the training programme: acute stress and posttraumatic stress disorder (PTSD).

The next step involved the adaptation of the content of the modules by trainers and designing sessions. The trainers were selected from NIMH and NINS, based on their previous mhGAP experience. One trainer had been closely involved in the global development of the mhGAP-IG and being well-versed in the content therefore guided the

adaptation and fellow trainers. The mhGAP 2.0 presentations and resources available online were used as a foundation on which the trainers developed their own presentations, translating mhGAP content into Bangla, incorporating data from Bangladesh and including examples of their local clinical experience of common mental health presentations.

The target audience for the training included physicians and counsellors (with a Bachelor's degree in psychology, social work or sociology) from government facilities and NGOs, serving both the host and Rohingya populations. As the same training content was delivered to all participants, the facilitators ensured that psychosocial interventions were emphasised as a key intervention in each module and clarified that pharmacological management was the responsibility of physicians.

Initial mhGAP training

A total of 21 participants attended the first training from 21 to 23 November 2017, including physicians from government facilities (8), humanitarian agencies working in the refugee camps (7) and psychosocial staff from humanitarian agencies (6).

The training was delivered in Bangla, using locally accepted and understood terminology and incorporated discussion of mental health within the context of different cultures, including both the host and Rohingya populations. The content was delivered mainly through interactive lectures, with participants' questions and needs guiding the depth and direction of each session. Role plays were used selectively when time permitted. Teaching videos from Bangladesh were employed where especially relevant to understand commonly encountered forms of mental health presentations, for example, to teach participants how to differentiate between seizures and pseudo-seizures. The published mhGAP videos were also used selectively to supplement (when time permitted) translation into Bangla to overcome the language barrier. Participants were also provided with hard copies of *mhGAP-IG (2.0)* and *mhGAP-HIG*, which the facilitators used to explain the algorithms for assessment and management, noting where first-line pharmacotherapy choice differed, according to availability of essential medicines in Bangladesh. Trainers distributed mhGAP quizzes at the end of each module to test participants' knowledge and discussed the answers within the group.

mhGAP refresher training

A three-day refresher workshop was held between 13 and 15 February 2018. A total of 19 participants (9 from the previous training and 10 new participants) attended, including physicians from government facilities (10), physicians from humanitarian agencies working in the refugee camp (3) and psychosocial staff from humanitarian agencies (6). Although the refresher training was aimed at consolidating skills of the previously trained participants, due to several factors (including staff turnover), it was challenging to ensure the same participants attended and some new participants attended instead. As such, for over

half the participants, the refresher training was their first introduction to mhGAP. Recognising this, the facilitators covered the same content in a similar depth as the original training.

The mode of delivery of the refresher training was also kept constant, but additionally included observation of a psychiatrist conducting a consultation with a patient experiencing mental health symptoms. The patient and their family provided their consent for this session and confidentiality was assured. The refresher training also included an introductory session on use of the mhGAP mobile phone application.

Supervision

As an essential part of implementation, supervision visits were held from 20 to 22 March 2018. Resource persons used a checklist which included a separate competency assessment and a systems assessment based on mhGAP tools. The competency assessment was adapted from the one provided in the *mhGAP Training of Health-care Providers (ToHP) training manual (For field testing)* (WHO, 2017a) and the system assessment from the *mhGAP Operations Manual 2018* (WHO, 2018a). To maintain and continue to build rapport with the participants, the same facilitators of both trainings were selected for supervision, in addition to an additional psychiatrist from Bangabandhu Sheikh Mujib Medical University. The supervisors were accompanied by WHO technical officers. The key objective of supervision was to coach the participants according to their needs, and to develop their skills and confidence in assessing and managing MNS conditions. Two modalities were used to conduct the sessions. The first modality was direct observation of a mental health consultation conducted by the participant with the consent of the patient. Participants provided feedback after the consultation, or guidance during it, as needed. The second modality was a case review session. Participants and supervisors discussed previously seen cases which the participants found most challenging for assessment, management and follow-up. Retrospective feedback was provided by the supervision team.

EVALUATION RESULTS

Trainings

After the completion of both trainings, the participants were asked to complete evaluation forms to assess the relevance of the content to their work, the structure of training, the quality of slides, the quality of trainers, the quality of activities/role plays, the number of opportunities for active participation and the overall quality of training. The evaluation form was a self-administered written questionnaire with mostly closed questions with a rating scale from 1 to 5 (1 = Poor, 5 = Excellent). The results of the evaluation were tabulated and analysed by the WHO technical officer.

All aspects of the training received an average score of over 3.5. The quality of trainers received the highest average rating of 4.9 and 4.7 in the initial mhGAP training and

refresher training, respectively. For the initial training, participants indicated that it was relevant to their work (average score 4.5) and rated highly the quality of slides (average score 4.7). The average score for the overall quality of the training was high, at 4.8 for the initial mhGAP training and at 4.2 for the refresher training (see Figure 1).

Participants in the initial mhGAP training were also asked to assess the level of their confidence to apply the training to their work. Over three quarters (16/21) of participants responded that they were 'very confident'. The number of participants responding extremely confident, moderately confident and not providing a response were 2, 2 and 1, respectively (see Figure 2). Participants were also asked how likely they were to assess and manage a person with a mental health condition after the refresher training. This question also had a rating scale from 1 to 5 (1 = Not at all, 3 = Maybe, 5 = Definitely). The average score for this question was 4.14 (see Figure 3). Due to limited time available, the knowledge component was assessed informally through the group's responses to the mhGAP quizzes at the end of each module and indirectly during supervision in the application of knowledge to clinical practice.

As the refresher training was originally designed for the participants from the initial training, only those who had attended both were asked about their application of learning since the first training. Two participants reported that they had applied the ECP and communication skills learned, and three participants reported that they had

applied the intervention and management procedures from the mhGAP training. Six different participants stated that the skills they had used from mhGAP were: changing attitudes towards persons with schizophrenia, MNS assessment and intervention procedure for persons with anxiety, depression, bipolar disorder, psychosis and neurodevelopmental disorder; ECP/communication skills for persons with acute stress disorder; communication, assessment and management skills for persons with depression, generalised anxiety disorder (GAD) and stress; counselling and therapeutic skills for persons with depression and

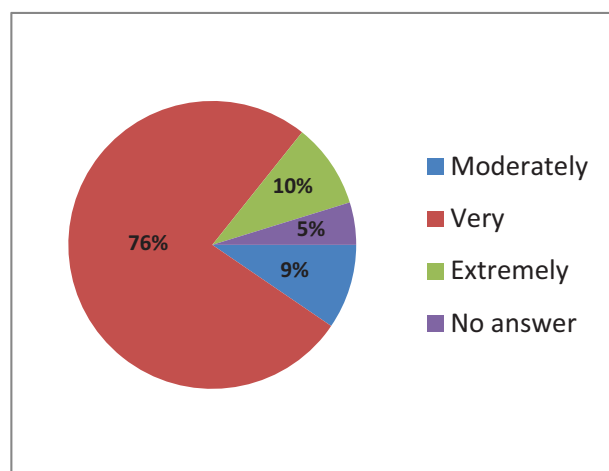


Figure 2: Participants' confidence level to apply the initial mhGAP training to their work (% participants). Note: Rating scale: Extremely (5), Very (4), Moderate (3), Slightly (2), Not at all (1).

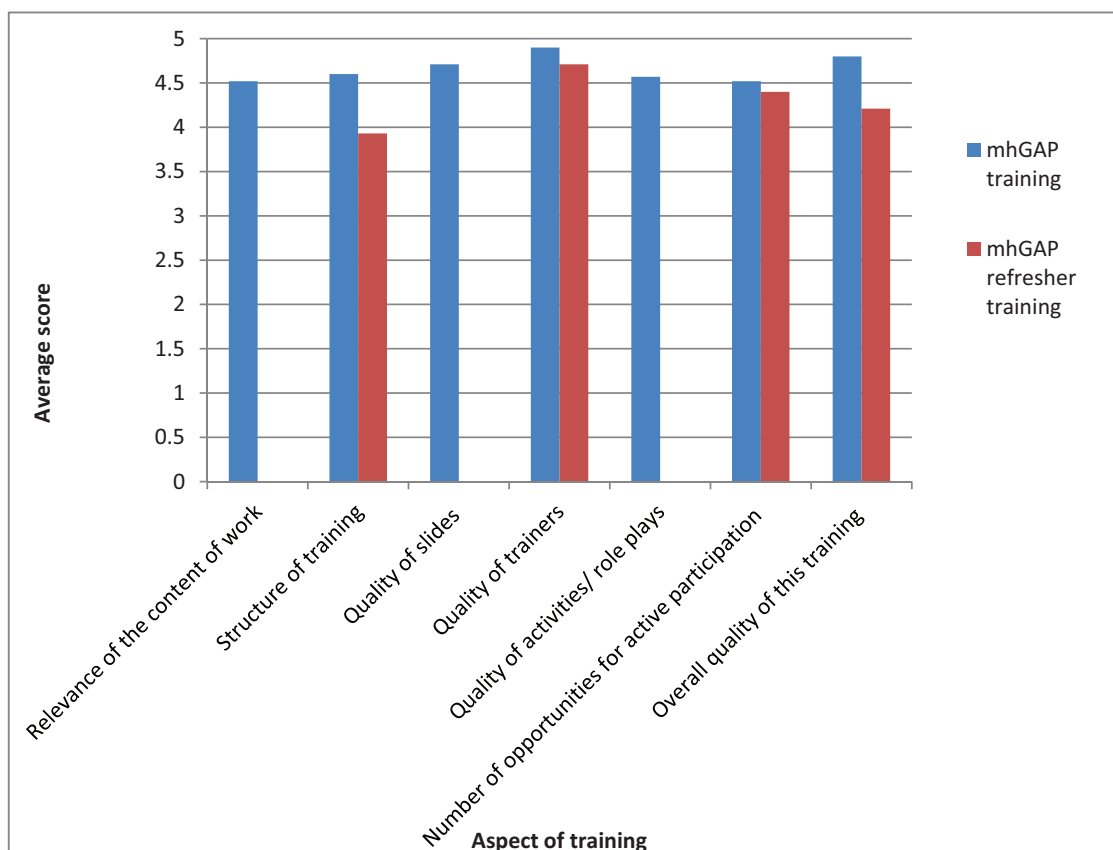


Figure 1: Results of the initial and refresher training evaluations. Note: Blank columns indicate this criterion was not included in the refresher training evaluation form.

anxiety disorders; and assessment skills for persons with epilepsy.

At the end of the trainings, the participants provided their comments and recommendations (see Table 1).

Supervision

Supervision involves the assessment of the practical application of theoretical knowledge and skills gained from

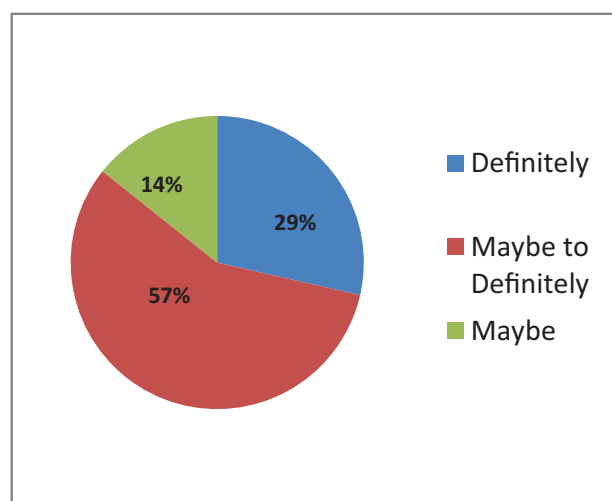


Figure 3: Likelihood of participants to assess and manage persons with mental health conditions following the refresher training (% participants). Note: Rating scale: Definitely (5), Maybe to definitely (4), Maybe (3).

training and provides an opportunity for further professional clinical skill development. Seven general physicians took part in an individual supervision session in March 2018. These were physicians who had received the initial mhGAP or refresher training. Among them, six were from government facilities and one was from a humanitarian agency.

During the observed consultation, the demonstrated skills most often rated as excellent were history taking, followed by communication and pharmacological interventions. Mental state examination and diagnosis were rated average for all. Most participants received a rating of average for the skills of psychosocial interventions and referral (see Figure 4).

The supervision visit also provided an opportunity for mhGAP participants to discuss challenging cases and difficulties encountered in implementing mhGAP training. Two participants shared a critical/challenging case.

An attempt was made to assess the impact of training on service delivery through the systems assessment. Consultation data were collected from participants in the supervision visit, based on their recall. In total, seven physicians reported providing an estimated 142 consultations for MNS conditions over the past month. Within these, the most frequent presentations were self-harm/suicide (83), stress-related conditions (31) and moderate-severe depression (4). These data estimates were not validated by case record review. Due to limited documentation, it was also not possible to assess pharmaceutical prescriptions and

Table 1: Participants' feedback on initial mhGAP training and mhGAP refresher training

Questions	mhGAP training	mhGAP refresher training
What was best about this training?	Simple training methods, organised presentations, active participation, role playing and enriched training materials. Training content was relevant to their work and will help them to understand priorities and mental health problems in their own profession. The trainers' competency (such as using easy language, realistic explanations and encouraging two-way communication) that allowed active participation and a friendly environment for participants.	
What did you learn from this training that you anticipate using most again?	Diagnosis of psychological disorders and knowledge of referral mechanisms, common symptoms, pharmacological and psychological interventions for depression, epilepsy, stress, anxiety and PTSD. Knowledge of mhGAP guidelines and effective communication skills. Felt enabled to identify common mental health problems and differentiate between neurosis and psychosis which would play a significant role in caring for people with mental disorders.	
What was most useful about this refresher training?		Recap and knowledge, case presentation, recognising importance of mental health, development of counselling skills, learning about diagnosis, lectures on different topics by excellent trainers.
What would you suggest to improve this training?	Content was too much for three days, so a longer duration is suggested. Practical or clinical session to gain a clearer idea of mhGAP implementation. Focusing on PTSD, acute stress and depression more, especially the management of these disorders. More role play, pictorial and video/graphic presentation to enable easy learning	The training could be improved by having more case presentations, active practical sessions with patients' on-site visit, monitoring and supervision, longer duration of training, better seating arrangement, more video presentations, group discussions and role plays.

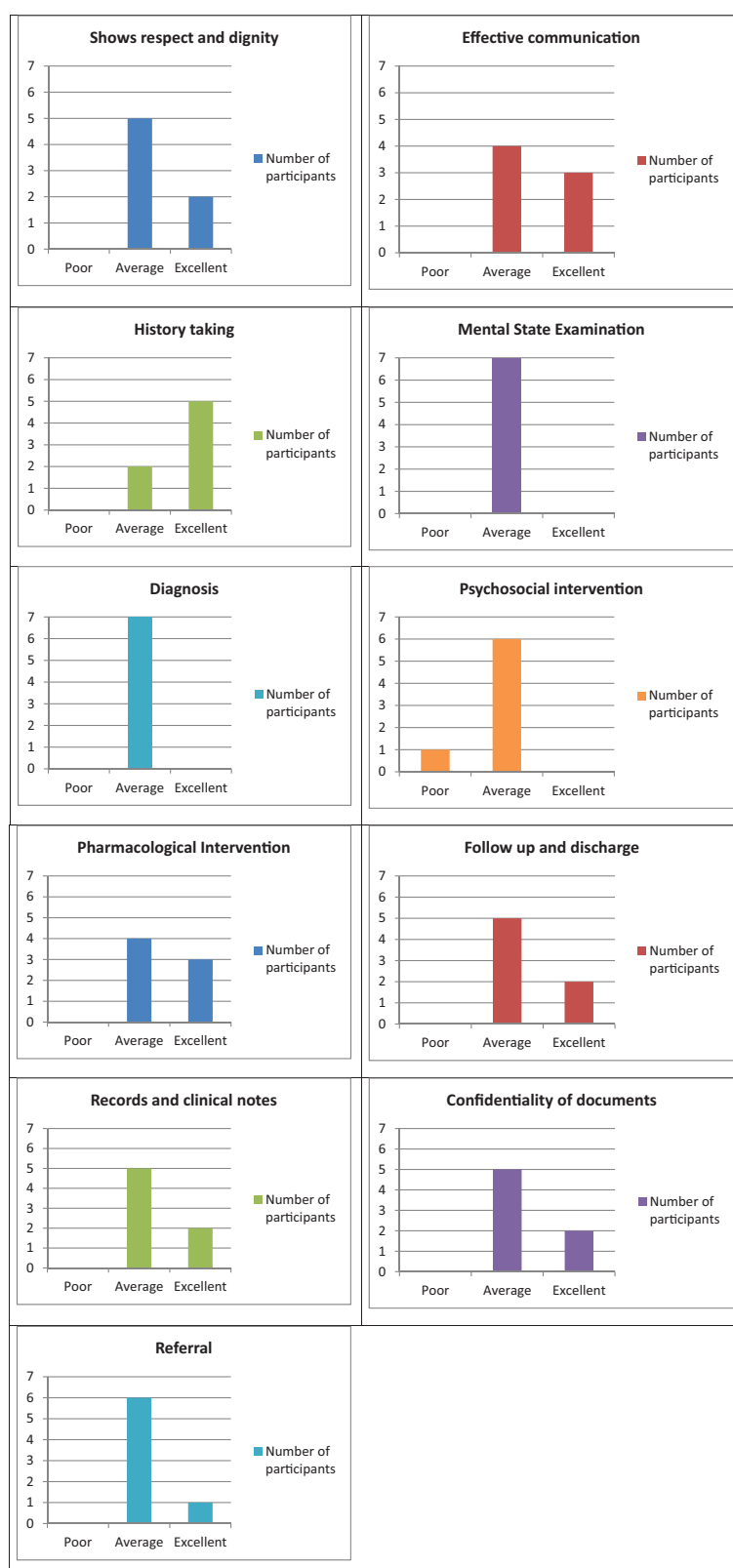


Figure 4: Competency assessments during supervision visits

number of referrals. The participants reported referring patients with self-harm and attempted suicide to Cox's Bazar Sadar Hospital, which is the first referral point at the secondary level of care.

Participants were asked about the percentage of their working time for providing mental health care. All reported that there was no dedicated time just for MNS conditions, rather

these consultations occurred within their daily schedule, along with consultations for all conditions. Out of seven facilities, five reported having effective mechanisms for patient consultation or that a referral mechanism was in place. All participants were using mhGAP to assess and manage MNS conditions. The participants' feedback for the supervision session is described in Table 2.

Table 2: Participants' feedback in supervision visit

Questions	Supervision
What are the major challenges to implement mhGAP in your practice?	Limited knowledge of antipsychotic drugs (which drugs to use, dosage and side effects), little experience with psychiatric patients.
What do you need next, and from whom, to continue to assess and manage mental disorders confidently and successfully in your practice?	Regular supervision by experts or peer group supervision for clinical practice, mhGAP training should continue, practical sessions (patient demonstration) to be included in the training, participants staying in Cox's Bazar for longer duration be selected for training to minimise drop out, awareness of mental health could be more focused, training on psychotherapy should be included.

DISCUSSION

mhGAP-IG is a tool utilised globally to address the treatment gap for mental health conditions. Our experience indicates that when mhGAP tools are adapted to national and local context, and training designed and delivered to a high quality with supervision, the knowledge and skills of nonspecialists to assess and manage priority MNS conditions can be enhanced. Our findings suggest that trainees are providing better quality mental health services in primary health care settings for both host and Rohingya populations.

Our experience of implementing mhGAP is supported by other studies of impact. To integrate mental health into primary health care, a successful training programme was conducted in Sri Lanka, the results of which indicated that participants' assessment and treatment of patients improved (Jenkins, Mendis, Cooray, & Cooray, 2012). In Sri Lanka, Pakistan and Jordan, results of trainings on mental health showed that these generally improved the mental health knowledge of primary health care workers (Budosan, 2011). In Lebanon, 152 primary health care providers (doctors, nurses and social workers) working with Iraqi refugees were trained in the identification, management and referral of people with mental health problems. The training included 12 theoretical training days, and a minimum of three on-the-job, supervised clinical sessions. The results showed an average of 12–25% improvement in knowledge of trainees, and 85% doctors and 91% nurses met minimum competency standards (Hijazi, Weissbecker, & Chammay, 2011).

mhGAP-IG was also used in Nigeria, contextualised for the local setting for an eighteen-month implementation programme. A well-supervised training model was utilised, with master trainers providing training for the facilitators, who conducted several rounds of training for frontline primary health care workers. A total of 198 primary care workers were trained in the detection and management of four MNS conditions: moderate to severe major depression, psychosis, epilepsy and alcohol use disorders, using the *mhGAP-IG*. Following training, there was a marked improvement in the knowledge and skills of the health workers and a significant increase in the numbers of persons identified and treated for MNS conditions, as well as an increase in referrals (Gureje, Abdulmalik, Kola, Musa, Yasamy, & Adebayo, 2015).

Challenges and lessons learned (including recommendations)

Our evaluation of the mhGAP approach revealed a positive increase in primary health care workers' capacity to provide mental health services and a high demand for and interest among practitioners in developing their skills for mental health service provision. The programme is also an example of effective collaboration between the government and WHO in an emergency response situation.

Several challenges were encountered in implementation and important lessons were learned. One critical lesson learned was that there is a need to develop further understanding of the cultural determinants and perceptions of mental health, especially within the Rohingya population. With such an understanding, training can be tailored accordingly to ensure a high degree of cultural competence and safety in service delivery.

The evaluation results demonstrate development of participants' skills, particularly in assessment of priority mental health conditions. It is evident, however, that further attention is required to build competence in pharmacotherapy provision and the delivery of psychosocial interventions, particularly WHO's *Problem Management Plus* (WHO, 2016b), *Thinking Healthy* (WHO, 2015b) and group interpersonal therapy for depression.

Our evaluation is process oriented, and therefore designed to focus on the quality of the training and application of skills in clinical practice. It did not comprehensively collect and verify data on actual services provided, their quality and impact. This reflects the need to strengthen the existing health information systems to collect data on service provision, including follow-up and referrals of patients, to ascertain whether mental health outcomes are improving. Routine health facility data collection also needs to be complemented by qualitative studies on patients' experience of these services and the impact on their quality of life. Similar information systems challenges have been highlighted in mhGAP implementation programmes in the region (Humayun et al., 2017). With the need to respond urgently to the crisis, our mhGAP training curriculum was developed using the best available knowledge of the national and emergency situation, and of the existing capabilities of primary health care workers. Ideally, the curriculum would have been developed formally and collaboratively with stakeholders and a training of trainers

undertaken, as per successful aspects of other mhGAP programmes (Humayun et al., 2017). As part of the national implementation of mhGAP, which will also contribute to emergency preparedness, the intervention guides have now been adapted to Bangladesh by DGHS, NIMH and WHO, and a formal training of trainers is being planned. Furthermore, tools such as the evaluation and supervision forms, pre-test and post-test questionnaires can be translated into Bangla. Although the mhGAP videos are a most effective teaching tool, the language barrier limited their utility. As such, these videos are also being translated and plans are developing for creation of new mhGAP videos specifically for Bangladesh.

A comprehensive forward and back referral system is essential for successful mhGAP implementation, as well as ensuring the provision of psychosocial interventions and a sustained supply of medicines. A locally based psychiatrist can provide a point of referral for specialist support. Following the situational assessment and recommendations, DGHS facilitated the placement of a psychiatrist in the Cox's Bazar Sadar Hospital. Access to this psychiatry service remains a challenge for those living in the camps. Regular outreach clinics conducted by the local psychiatrist in the camps and Upazila Health Complexes may help to increase access to specialised care for both Rohingya and host populations. This would also provide an opportunity for supervision and support of general physicians trained in mhGAP working in these facilities and areas. Humanitarian agencies working in Cox's Bazar have also engaged local and international psychiatrists, and general physicians with previous training in mhGAP, who receive referrals.

One of the most critical challenges was and remains ensuring the sustainability of mhGAP implementation and scaling-up. This training included a relatively small number of health care workers to maximise effective participation and learning. Furthermore, while we attempted to consolidate knowledge and skills in the refresher training, the high turnover of staff working in Cox's Bazar limited our ability to call back the same participants. Regular and frequent trainings are required to ensure health facilities continue to have a staff member onsite who can provide quality mental health care. The content of these trainings will need to be periodically reviewed to address emerging concerns, for example, substance abuse.

Sustainability of implementation also requires sustained technical support for mhGAP implementation and follow-up of participants. During this implementation, one supervision visit was conducted for seven participants. The supervision visit was well received by participants and highly appreciated. To sustain impact, however, and to monitor the quality of service provision, long-term locally based clinicians also need to be engaged to provide supervision to more participants. This would support primary health care workers to continually develop their skills and increase and maintain their confidence to provide mental health care.

To address these concerns, particularly considering the protracted emergency, WHO has engaged international and local psychiatrists to deliver regular mhGAP trainings to healthcare workers, supervision skills training to physicians and regular direct supervision for participants. From 2018 to date, mhGAP training has been provided to 250 participants from government and partner facilities.

CONCLUSION

Our experience of mhGAP adaptation and implementation reaffirms the value and effectiveness of this approach to enable greater access to mental health care, especially in humanitarian crises. Critical challenges remain such as ensuring the sustainability of impact and enabling a complete integration of mental health into primary health care. These challenges can best be addressed by strengthening all building blocks of the health system, and '*building back better*' the national mental health care system. Collaboration between government, specialised institutes, NGOs, academia and development and humanitarian agencies will be essential to achieve this vision.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

- Budosan, B. (2011). Mental health training of primary health care workers: Case reports from Sri Lanka, Pakistan and Jordan. *Intervention*, 9 (2), 125-136. doi: 10.1097/WTF.0b013e328348e00e
- Gureje, O., Abdulmalik, J., Kola, L., Musa, E., Yasamy, M. T., & Adebayo, K. (2015). Integrating mental health into primary care in Nigeria: Report of a demonstration project using the mental health gap action programme intervention guide. *BMC Health Services Research*, 15(1). doi: 10.1186/s12913-015-0911-3
- Hijazi, Z., Weissbecker, J., & Chammay, R. (2011). The integration of mental health into primary health care in Lebanon. *Intervention*, 9(3), 265-278, doi: 10.1097/WTF.0b013e32834d14b1
- Hossain, M. D., Ahmed, H. U., Chowdhury, W. A., Niessen, L.W., & Alam, D.S. (2014). Mental disorders in Bangladesh: A systematic review. *BMC Psychiatry*, doi: 10.1186/s12888-014-0216-9

- Humayun, A., Haq, I., Khan, F. R., Azad, N., Khan, M. M., & Weissbecker, I. (2017). Implementing mhGAP training to strengthen existing services for an internally displaced population in Pakistan. *Global Mental Health*, 4, e6. doi: 10.1017/gmh.2017.1
- International Organization for Migration. (2018). *Assessment of mental health and psychosocial needs of displaced Rohingya refugees*. Cox's Bazar, Bangladesh: International Organization for Migration.
- Jenkins, R., Mendis, J., Cooray, S., & Cooray, M. (2012). Integration of mental health into primary care in Sri Lanka. *Mental health in Family Medicine*, 9(1), 15-24.
- World Health Organization (WHO). (2010). *The mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders for non-specialist health settings*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/publications/mhgap_intervention_guide/en/
- WHO. (2015b). *Thinking healthy: A manual for psychosocial management of perinatal depression. (Generic field-trial version 1.0)*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/maternal-child/thinking_healthy/en/
- WHO. (2016a). *mhGAP Intervention Guide (mhGAP-IG) for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/
- WHO. (2016b). *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity. (Generic field-trial version 1.0)*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/emergencies/problem_management_plus/en/
- WHO. (2017a). *mhGAP Training of Health-care Providers (ToHP) training manual (for field testing)*. World Health Organization. Retrieved from https://www.who.int/mental_health/mhgap/training_manuals/en/
- WHO. (2017b). *Depression and other common mental disorders: Global health estimates*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/management/depression/prevalence_global_health_estimates/en/
- WHO. (2017c). *Mental health status of adolescents in South-East Asia: Evidence for action*. New Delhi: Regional Office for South-East Asia, World Health Organization. Retrieved from <https://apps.who.int/iris/bitstream/handle/10665/254982/9789290225737-eng.pdf>
- WHO. (2018a). *mhGAP operations manual: Mental Health Gap Action Programme (mhGAP)*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/mhgap/operations_manual/en/
- WHO. (2018b). *Mental health ATLAS 2017 Bangladesh profile*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/evidence/atlas/profiles-2017/BGD.pdf
- WHO (2018c). *Age-standardized suicide rate, 2016. Global Health Observatory*. Retrieved from <http://apps.who.int/gho/data/node.main.MHSUICIDEASDR?lang=en>
- WHO. (2019). *Bi-weekly situation report, 16*. Bangladesh: World Health Organization. Retrieved from <http://www.searo.who.int/bangladesh/sitrep-16-cxb-ban2019.pdf>
- World Health Organization & United Nations High Commissioner for Refugees. (2012). *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/
- World Health Organization & United Nations High Commissioner for Refugees. (2015). *mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*. Geneva: World Health Organization. Retrieved from https://www.who.int/mental_health/publications/mhgap_hig/en/