



## Literature Reviews

# Community Mental Health Services in Pakistan: Review Study From Muslim World 2000-2015

Serviços de saúde mental comunitária no Paquistão: Estudo de revisão sobre o mundo islâmico em 2000-2015

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## Abstract

**Aim:** This study attempted to analyse the potential of two primary sources of mental health service delivery at a grassroots level, religious/faith healers and community/lady health workers, and how they can be effectively used to deliver mental health services in a resource-scarce country like Pakistan.

**Method:** A literature review was carried out for relevant studies conducted in Muslim countries between 2000 to 2015 reporting empirical results. Using the inclusion criteria, thirteen studies were selected for the review.

**Results:** The presented studies suggest that the main proportion of mental health patients in countries with major Muslim population including Pakistan, visit religious/faith healers first for treatment, however all studies are silent about the outcomes through these healers. The only potential visible outcome of contacting religious/faith healers is the identification of mental health cases. However, community/lady health workers with minimal training appeared to be a beneficial source of mental health service delivery in communities.

**Conclusion:** In a resource scarce country like Pakistan, networking with religious/faith healers can be established for effective identification and referral of mental health cases whereas strong and already existing community/lady health workers system can be used as a first level to deliver mental health service at the doorstep.

*Keywords:* mental health, religious/faith healers, community/lady health workers, low and middle- income countries

## Resumo

**Objetivo:** Este estudo tenta analisar o potencial de duas fontes primárias de prestação de serviços de saúde mental num nível de base do sistema, curandeiros religiosos/de fé, mulheres trabalhadoras de saúde/profissionais de saúde comunitária, e como estas podem ser efetivamente usadas para fornecer serviços de saúde mental em países de recursos escassos, como o Paquistão.

**Método:** Uma revisão de literatura foi realizada sobre estudos relevantes realizados em países muçulmanos entre 2000 e 2015, com resultados empíricos. Usando os critérios de inclusão, trinta estudos foram selecionados para a revisão.

**Resultados:** Os estudos apresentados sugerem que a principal proporção de pacientes de saúde mental em países com grande população muçulmana, incluindo o Paquistão, visita primeiramente curandeiros religiosos / de fé para tratamento, no entanto, todos os estudos não explicitam os resultados obtidos por esses curandeiros. O único resultado potencial visível de contatar os curandeiros religiosos / de fé é a identificação de casos de saúde mental. No entanto, mulheres trabalhadoras de saúde/profissionais de saúde comunitária, com treinamento mínimo parecem ser uma fonte benéfica de prestação de serviços de saúde mental nas comunidades.

**Conclusão:** Num país com recursos escassos como o Paquistão, estabelecer redes com curandeiros religiosos / de fé pode ser feito para identificação eficaz e encaminhamento de casos de saúde mental, enquanto um sistema forte e já existente de trabalhadores comunitários pode ser usado como um primeiro nível para prover serviços de saúde mental à porta de casa.

[Note. Metadata in the Portuguese language provided by PCH].

*Palavras-Chave:* saúde mental, curandeiros religiosos/de fé, trabalhadoras de saúde/profissionais de saúde comunitária, países de rendimento baixo/médio

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## Mental Health Worldwide in Low and Middle Income Countries and Pakistan

It is estimated that 50% of the individuals in the developed and 85% in developing countries have mental health problems, but are unable to receive any treatment (Pescosolido & Lafsdottir, 2013). Globally, mental illness including schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use disorder constitutes 13% of the total disease burden and there are about 450 million mental health patients worldwide (Global and Cultural Mental Health, 2013). In 2013, mental and substance-use disorders accounted for 1,834/100,000 of global Disability Adjusted Life Years (DALYs) (Charara et al., 2017).

Mental illness problem is more severe in Low and Middle Income Countries (LAMIC) since 80% of the total mental health patients live in such countries (Thyloth, Singh, & Subramanian, 2016). According to estimates, mental disorder burden constitutes around 11.1% of the total disease burden in LAMIC (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). The World Health Organization (WHO) estimates that LAMIC bears 86% of the global suicide rates which is the direct outcome of the mental illness (Hendin et al., 2008). A study on East Mediterranean Region (EMR), which comprises of mostly LAMICs and of which Pakistan is a part, shows that mental disorder contributes to 1,894 DALYs/100,000 of the population as compared to 1,834 DALYs/100,000 globally (Charara et al., 2017).

As country profile of Pakistan demonstrates, 10-16% of people suffer from mild to moderate, whereas the 1% suffer from severe mental illness (Gaddit, 2007). Mental health disorder constitutes the 11.9% of the total global disease burden (World Health Organization, 2011) and contributes to the 1,607 DALYs/100,000 of the population in Pakistan (Charara et al., 2017). Identifying the Common Mental Disorder (CMD) rate in Pakistan including depression and mental disorders, Mirza and Jenkins estimated the 34% of the overall CMD prevalence (Mirza & Jenkins, 2004). Irfan (2013) estimates that 60% of those who attend primary care clinics have diagnosable mental disorder; about 154 million suffer from depression; 25 million from schizophrenia; 91 million from alcohol use; 15 million by drug use; 50 million from epilepsy; 24 million from Alzheimer and other dementias, and around 877,000 die by suicide every year.

These alarming figures of mental illness in Pakistan are due to several social, cultural and economic reasons. Since 2001, the security situation in the country is quite volatile. The terrorism and war on terror including Taliban and Al-Qaida presence in the country, suicide bombings, ever rising human death toll, infrastructural destruction, military operations against terrorists, drone attacks and internally displacements are some of the reasons for higher mental illness rates (Husain, Chaudhry, Afridi, Tomenson, & Creed, 2007; Khalily, 2011). Eco-

nomically there is very little investment in Pakistan on mental health care, further aggravated by a dire shortage of skilled workers (Siddiqi & Siddiqi, 2007). The Pakistan government spends 0.9% of the total gross domestic product (GDP) on health which amounts to \$9.31 per person per year which is way less than the international recommendation of \$60 per person per year (Zhu, Allen, Kearns, Caglia, & Atun, 2014). The total mental health budget merely stands at the 0.04% of the total health budget in Pakistan (Humayun, 2016). Nationally, the 12.4% of people live below the poverty line and country's unemployment rate stands at the 6% (Asian Development Bank, 2016), which further aggravates the problem related to mental health services access.

Culturally, mental health is widely considered due to supernatural causes, such as, sorcerer, witchcraft and evil eye (Kishore, Gupta, Jiloha, & Bantman, 2011), which restrain people from accessing mental health services in Pakistan. Lack of awareness about mental health services is also a barrier. A recent study has shown that there is little awareness of cognitive behaviour therapy or family-based cognitive behaviour therapy among youth in Pakistan and mostly mental health patients contact their General Physicians (GP) for their concerns (Ali, McLachlan, Kanwar, & Randhawa, 2017). Religious barriers are also a reason for not accessing mental health services in Pakistan, for example, viewing illness as a source to connect to God and perceiving it as a blessing in Muslim countries, or taking it as punishment from God and focusing more on religious deeds, such as, more prayers to cure the disease or contacting the religious leaders instead of availing of the medical services (Ciftci, Jones, & Corrigan, 2012).

## Mental Health Service Delivery in Pakistan

As far as mental health service delivery is concerned in Pakistan, there are mainly three formal and informal sources. Formal sources include public sector hospital based services and community based services through public psychiatric units and through Non-Governmental Organizations (NGOs). Informal mental health services involve religious and faith healers.

As far as hospital based mental health services are concerned, according to World Health Organization (2011), there are only 520 certified psychiatrists and 480 psychologists in Pakistan. For the population of 190 million there are less than 3,000 psychiatrist inpatient beds and there are four major psychiatric hospitals in the country which are associated with mental health outpatient facilities (Taj, 2016).

About community based psychiatric units, Ali, Lalani, and Charania (2015) state that there are only 624 inpatients units which provide a total of 1.926 beds per 100,000 population. Tharani, Farooq, and Naveed (2012) estimate that there are around 600 mental health social workers in Pakistan. However, Taj (2016) estimates that there are around 3,145 social workers (1.87 per 100,000 population) in Pakistan's mental health sector.

The third informal, but most widely used source of mental health service delivery, is through religious and spiritual healers due to the issues of less stigma, low cost and easy accessibility (Gaddit, 2007). In LAMIC, especially in South East Asian countries, mental illness is still considered due to possession or caused by evil, Jinn or other kind of supernatural forces (Afridi, 2008; Mubbashar, 2003). A wide range of literature suggests that families and religious figures are a crucial source of mental health services in Muslim Communities (Ciftci et al., 2012). Aloud and Rathur (2009) in their study on American Muslims found that 19% of the participants expressed their willingness to seek help from religious leaders at the first instance in comparison to the 11% from mental health professionals. Similarly, in his study on United Arab Emirates Muslims, Al-Darmaki (2003) found

that participants reported greater willingness to avail help from religious leaders in comparison to mental health professionals.

## Problem Statement

There are ongoing difficulties in providing good community mental health services in Pakistan due to the problems of low budget for health care; scarcity of mental health practitioners; stigma attached to psychiatric care; poor mental health facilities; limited awareness of mental health issues; illiteracy; negative concepts of mental illness; reliance on unproven alternative medicine; and low prioritisation of mental health by the government (Ali et al., 2015; Mubbashar, 2003; WHO, 2011).

Since the last few decades, rapid changes have been recorded in Pakistan towards provision of mental health services, yet the situation is not satisfactory both in term of the trained staff, patients' care and facilities (Afridi, 2008). The country has only five mental health hospitals which are in the main cities of the country and there is no community based residential facility in the country (Molodynski & Rugkasa, 2016). The distribution of mental health human resources between urban and rural areas is also disproportionate. The average of psychiatrists and mental health nurses in urban areas is 2.29 and 0.15 times greater than rural areas respectively (WHO, 2009).

Although mental health is a part of the health care policy and planning in Pakistan, primary or community mental health care is the area of continuous negligence and still most of the resources are spent on hospital based psychiatric services (Irfan, 2013). In view of the insufficient number of mental health professionals in Pakistan, unless mental health is not incorporated in primary health care, the majority of the people will be unable to access any mental health professional in their lifetime, hence eventually missing the prospects of early identification and treatment of disorder (Irfan, 2013).

In view of the fact that Pakistan has limited resources and other health issues compete strongly with mental health initiatives, such as, stigma, cultural barriers and urban rural disproportion, the most feasible strategy will be the horizontal integration with existing primary health care system, thereby strengthening the system rather than creating a parallel mental health care system (Irfan, 2013). Horizontal integration means bringing together professionals, services and organizations that operate at the similar levels in the hierarchy (England & Lester, 2005). There are many examples around the globe where such integrated mental health care systems have worked successfully, for instance, in United Kingdom, Primary Care Trust Unit which was responsible for managing, commissioning and providing primary mental health care services to 100,000 patients was given additional responsibility to evaluate and commission all the mental health services in the country (England & Lester, 2005).

Pakistan has a very strong existing network of Community Health Workers (CHW), for instance, polio vaccination teams and lady health workers. CHW are increasingly acknowledged as a critical connection between improving access to services and achieving health related goals. Due to the financial and human resources constrictions in developing countries, CHWs are expected to do more without necessarily receiving the needed support (Jaskiewicz & Tulenko, 2012). In view of unmet rural health needs and urban slum population in Pakistan, the Lady Health Worker Cadre was created in 1994 to provide essential primary health care services including health promotion, disease prevention, curative and rehabilitative services, and family planning at community level. These lady health workers are provided 18 months training, followed by 12 months on-job training.

These workers are selected and reside in their own communities and each worker is responsible for 1000 individuals. Each worker is attached to a government health facility from which they receive training, a small allowance and medical supplies. If these health workers are additionally trained for providing mental health services, they can be a very effective tool to deliver community mental health services. Lady health workers in Pakistan are expected to be the agents of change within their communities by providing integrated preventative and curative health services to their neighbours by utilizing their peer status to connect with patients and navigate local customs, languages, and social relationships more effectively than outsiders. (Zhu et al., 2014).

Similarly, the majority of mental health patients in Pakistan prefer religious and faith healers as first point of contact for treatment and these leaders have substantial psychological influence on patients' and their families' mentality. Faith healers are a powerful source of care for people with mental health problems in Pakistan, especially to women and people with little education (Saeed, Gater, Hussain, & Mubbashar, 2000). If these religious and faith leaders are taken on board and trained to provide mental health counselling, it can be very productive in view of the fact that the largest number of mental health patients goes to religious leaders. Networking with community health workers and religious leaders can produce a very effective system to address the mental health service delivery issue in Pakistan.

## Aim

The aim of this paper is to find the answer to the question “Can involving community health workers (non-mental health background) and religious/faith leaders in Pakistan help to devise a better network for mental health care delivery?”

This study is part of a bigger research project which was undertaken to trace the impacts of community organisations in the provision of mental health services in disadvantaged communities. It was during the project that role of religious leaders also emerged as a major theme regarding the provision of mental health services in disadvantaged communities and the author decided to extend the literature review to cover this aspect too.

## Method

Literature has been reviewed to identify and analyse the relevant studies to synthesise the results. The literature review methodology carries several advantages, such as: helps to provide a context and justification of the research; establishes where the current research fits into the existing body of knowledge; enables to learn from previous theory on the subject; describes how the subject has been studied previously; highlights gaps and flaws in previous research; justifies that work in adding to the understanding and knowledge on the field and help to refine and refocus the topic (Wonjohi, 2012).

The major databases accessed for relevant literature were EBSCOhost, JSTOR, Sage Journals, Elsevier and Web of science. Search on the internet was made through Google Scholar. Upon retrieval of relevant literature, the reference lists were also consulted for further relevant articles. The key terms used were religious healers, faith healers, community health workers, lady health workers, mental health in developing countries and mental health in Pakistan. The three basic Booleans “and”, “or”, “not” were also used to interlink the multiple searching terms and concepts.

The time frame chosen for this review was from 2000 to 2015 in order to yield most recent empirical results. A main reason for choosing this time frame is the post 9/11 terrorism related circumstances which have brought serious consequences to the Muslim countries especially. Terrorism-hit countries like Iraq, Afghanistan, Sudan, Somalia and Pakistan have seen a dramatic rise in mental health patients due to persistent disastrous situation. This time frame will help to trace the trends about mental health care after 9/11 and its implications on Muslim population.

Only those studies were included for review which reported community based mental health service delivery programs involving community health workers, religious and faith leaders in LAMIC with major Muslim population. The reason for selecting LAMIC with major Muslim population is because research suggests that use of spiritual services for mental illness is more common in Islamic Society (Al-Krenawi, Grahani, Ophir, & Kandah, 2001). Upon using the inclusion exclusion criteria, 13 studies were finally selected for review.

## Results

### Religious and Faith Healers

Saeed et al. (2000) conducted a very first study of this kind in Pakistan to investigate the prevalence, classification and treatment of mental disorders among attenders at faith healers by interviewing 139 attenders visiting five faith healers. The authors conclude that people who consult the faith leaders consider the healers as their spiritual guide and consider this an honour to follow their wishes. They further comment that these faith leaders treat the patients according to their cultural value system and their continual role as a source of mental health service provider confirms people's perceptions about the usefulness of their consultation and treatment.

Qidwai (2003) held a study on 387 mental health patients who visited family physicians in Karachi, Pakistan, to evaluate the usage pattern of services by spiritual healers. The results indicated that 45 (11.6%) respondents had already used the services of spiritual healers. The main reasons indicated by respondents to visit spiritual leaders were: recommendation of someone; believe in spiritual healers; inability of doctors to cure and reliability of spiritual leaders.

Farooqi (2006) conducted a study in Lahore, Pakistan, with 87 adult psychiatric patients to explore the type of common traditional mental health practices availed by patients. All the patients who participated in the study indicated that they had availed some type of traditional healing including Islamic faith before seeking professional help. Most of the traditional healings were utilised by women who are mostly under-privileged, uneducated, vulnerable and suggestible.

Salem, Saleh, Yousef, and Sabri (2009), in a descriptive cross sectional epidemiological survey, studied the help seeking behaviour of 106 mental health patients in the psychiatric department of Al-Ain hospital, United Arab Emirates. Results indicated that prior to availing psychiatric service, the 44.8% of the patients consulted faith healers. The main reason for consulting faith healers was their believe on black magic, evil eye or possession by Jinni as a cause of their illness.

Giasuddin, Chowdhury, Hashimoto, Fujisawa, and Waheed (2012) tried to investigate the referral patterns and delay in diagnosis and treatment before reaching mental health professionals by interviewing 50 consecutive

new patients in a psychiatry outpatient department in Bangladesh. The results identified that 84% of the interviewed patients consulted other sources before going to a mental health professional, hence delaying the professional treatment from 8-78 weeks. The most common source of initial consultation was general physicians (44%) followed by native or religious healer (22%).

[Girma and Tesfaye \(2011\)](#) conducted a cross sectional study on 384 psychiatric patients at Jimma University Specialized Hospital (JUSH) in Ethiopia to determine the treatment seeking behaviour pattern of mental illness. The results showed that 30% (116) of the patients sought traditional healing through religious healers before availing professional treatment. There was an average delay of 52.1 weeks before availing professional help.

[Bathla, Chandna, Bathla, and Kaloiya \(2015\)](#) in a longitudinal study in North Indian psychiatric hospital on 1180 mental health patients for four years, studied the socio-demographics of patients who used psychiatric consultation/treatment after visiting faith leaders, sources of referral to faith leaders, mode of treatment, duration and improvement after treatment from faith leaders. Results showed that the 88% of patients visited faith healers more than once, but only the 2.12% reported improvements after treatment, though no patient reported long term improvement and the 67% visited faith healers at their own.

Several other studies, for instance, [Lasebikan, Owoaje, and Asuzu \(2012\)](#), in Nigeria, and [Mirza, Mujtaba, Chaudhry, and Jenkins \(2006\)](#) in Pakistan suggest that religious and faith healers are the most popular choice for mental health patients as first point of contact due to various reasons in LAMIC with major Muslim Population.

## Community Health Workers

[Ali et al. \(2015\)](#) conducted a randomized control trial on 366 anxious and/or depressed women in lower middle class, semi-urban community in Karachi, Pakistan. A total of 21 women from same community were trained for 33 hours in 11 sessions as community counsellor and 124 subjects in the intervention group were counselled once a week for eight weeks. The results indicated a 35% reduction in the levels of anxiety and/or depression of intervention group in comparison to the control group of 91 participants.

[Rahman, Malik, Sikander, Roberts, and Creed \(2008\)](#) carried out a cluster randomized control trial by integrating a cognitive behaviour therapy-based intervention into the routine work of community based primary health workers in rural Pakistan for treatment in perinatal depression during pregnancy. A total of 463 pregnant women were placed in intervention group and 440 in control group which did not receive any intervention. After six months, only 97 (23%) mothers were found affected by depression in the intervention group in comparison to 211 (53%) in the control group. These effects were sustained at 12 months.

[Neuner et al. \(2008\)](#) conducted a randomized control trial of effective treatment of posttraumatic stress disorder (PTSD) on 277 Rwandan and Somalian refugees in Uganda through training nine lay community members for interventions. Three cluster groups were formulated: strictly manualized narrative exposure therapy (NET), more flexible trauma counselling (TC), and no-treatment monitoring group (MG). Results indicated that after intervention, PTSD could not be established in 70% NET and 65% TC whereas only 37% in MG did not meet PTSD criteria.

Vijayakumar and Kumar (2008) piloted a non-randomized control study on 2004 Asian Tsunami survivors who lost their close family members in India through intervention by training six health volunteers in providing mental health support to the affected family members. Results indicated that the chances of reporting depressive symptoms and general psychological distress were lower among participants who received intervention on constant bases in comparison to those who were not provided with intervention.

Ali, Ali, Azam, and Khuwaja (2010) carried out a quasi-experimental study in Pakistan by training two common community women in under privileged communities to conduct one hour counselling sessions for eight weeks to 102 pregnant women diagnosed with anxiety/depression. The training included basic information regarding anxiety/disorder, stress/anger management and communication/counselling skills. The results indicated a significant reduction in the level of anxiety/depression, recovery, decrease in the rate of recurrence and increase in the duration before relapse.

Armstrong et al. (2011) conducted a pre-test/post-test study in rural India on mental health training of 70 community health workers at three stages: baseline, completion and three month follow up after the training. The training was four days involving enhanced recognition of mental disorders, appropriate response and referral, service support to patients and families and improvement of mental health promotion in communities. The results showed that the training course improved participants' ability to recognise a mental disorder in a vignette, and reduced participants' faith in unhelpful and potentially harmful pharmacological interventions. There was also evidence of minor reduction in stigmatizing attitudes.

## Discussion

Religious and faith healers are the most commonly used source of mental health consultation in LAMIC with major Muslim population, as evident from the studies presented above and shown in Table 1. Although most of the studies reported that a major proportion of mental health patients in the Muslim countries prefer to consult religious/faith based healers, yet they are silent about the practical outcomes of those consultations. However almost all the scholars agreed about the usefulness of religious/faith based healers in mental health services provision despite the absence of concrete outcomes. As Abu-Ras, Gheith, and Cournos (2008) also posit that Imams (religious leaders) have an important role in dealing with mental health illness in Muslim countries. According to Bashir (2016), mental health patient's strong spiritual and religious values acquire a well-built foundation for therapy and a suitable faith-healing setup which provides a supportive, non-threatening and reassuring setting to cure mental illness.

The religious/faith healers have a strong influence on their followers, therefore their counselling can benefit the patients in minor and mild cases, for instance, situational stress, anxiety and depression. A belief-supportive milieu plays a very positive role in the recovery of mentally ill patients in comparison to the long-term stressful hospitalization (Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002).

Table 1

*Studies Regarding Religious/Faith Based Healers*

Author/s and Year	Location	Sample size	Results
Saeed et al. (2000)	Pakistan	139 mental health patients visiting faith healers	Patients considered faith healers effective and felt honour visiting them
Qidwai (2003)	Pakistan	387 mental health patients who visited family physicians	45 patients (11.6%) had visited faith based leaders before contacting medical physicians
Farooqi (2006)	Pakistan	87 psychiatric patients	All patients had availed traditional/spiritual healing before availing professional help
Salem et al. (2009)	United Arab Emirates	106 mental health patients in psychiatric department in a public hospital	44.8% reported conducting faith healers before availing professional services
Giasuddin et al. (2012)	Bangladesh	50 consecutive patients in psychiatric outpatient department	84% reported conducting faith healers before availing professional services
Girma and Tesfaye (2011)	Ethiopia	384 psychiatric patients at Jimma University Specialized Hospital	30% availed faith based services before contacting professional services
Bathla et al. (2015)	North India	1180 mental health patients in a psychiatric hospital	88% patients visited faith healers more than once

These religious and faith healers can also be a good source of referral of chronic and severe cases of patients to mental health professionals. Mubbashar (2003) comments that by educating faith healers and social congregations at mosques can lead to improved rates of detection of mental illness for utilisation of primary care services. Hamdan (2009) asserts the need to integrate the religion into mental health treatment in view of the collectivist nature of Muslim culture. Schoonover et al. (2014) also emphasize that traditional faith based healers are an integral part of their communities and so commonly used as resources, therefore the collaboration between traditional healers and medical practitioners would result in significant outcomes.

One of the major problems for involving religious/faith based healers in mental health recovery services is the lack of any formal training in addressing mental health issues (Abu-Ras, Gheith, & Cournos, 2008). Moreover, in a disadvantaged, uneducated and unaware society, fake faith healers also take the advantage of the situation for the lust of the money and use dangerous and inappropriate methods to cure the mental illness which must be curbed at government level (Bashir, 2016). However, this would need a strong legislation, networking and training with religious and faith healers.

Repeatedly studies have indicated the ample usefulness and advantage of training lay community health workers for incorporating mental health into primary health care in LAMIC. This has further been supported by the studies presented in this review and shown in Table 2. According to an estimate, there are currently five million community health workers worldwide providing primary health care services at communities' level (Perry, Zulliger, & Rogers, 2014). The importance of community health workers can be envisaged by the fact that one million community health workers were trained in 2015 resource-scarce Africa to provide the primary care at community level (One Million Community Health Workers Campaign, n.d.).

Table 2

*Studies Regarding Community Health Workers*

Author/s and Year	Location	Sample size	Type on intervention	Results
Ali et al. (2015)	Pakistan	366 depressed women from low middle class divided into 2 groups; intervention group and control group	21 community workers provided counselling to an intervention group for 8 weeks. Control group was not provided counselling	35% reduction in depression in intervention group as compared to control group
Rahman et al. (2008)	Pakistan	463 pregnant women in intervention group and 440 in control group	Cognitive behaviour therapy was incorporated in routine work of community health workers. Intervention group received integrated counselling whereas controlled group did not	Only 97 women (23%) in intervention group were diagnosed with depression in intervention group as compared to 211 (53%) in control group
Neuner et al. (2008)	Uganda	277 Rwandan and Somalian refugees divided into 3 groups; strictly manualized narrative exposure therapy (NET), more flexible trauma counselling (TC) and no-treatment monitoring group (MC)	Trained 9 community workers and provided extensive counselling to NET group, mild counselling to TC group and no counselling to MG group.	Post-traumatic stress disorder was not found in 70% NET, 65% TC and only 37% in MG group.
Vijayakumar and Kumar (2008)	North India	Unknown	Trained 6 community workers to counsel affected families of Asian Tsunami in 2004	Less symptoms of depression and psychological distress in families received intervention as compared to those who did not
Ali et al. (2010)	Pakistan	102 pregnant women with anxiety/depression	Trained 2 community workers to provide counselling to women	Significant reduction in anxiety/depression and decrease in the rate of recurrence and increase in duration before relapse
Armstrong et al. (2011)	Rural India	Unknown	Trained 70 community workers in 3 stages, baseline, completion and 3 months follow up after training	Training courses improved workers' ability to recognise mental disorder skills to use professional and appropriate interventions

Pakistan has one of the world's biggest community health workers network in form of lady health workers (American Academy of Family Physicians Foundation, n.d.) which can be used for mental health service delivery through little extra training. In Pakistan, community health workers' related provision of health interventions significantly recued the onset of hypertension in children and young adults. Socially Pakistan is a strongly connected community where people are strongly interconnected within their communities and use of health workers from the same communities can produce significant results. Previous studies have shown that community based approaches result in significant outcomes, not only because they are cost effective but due to the establishment of community ownership and sustainability (Pearson et al., 2001).

Moreover, as research indicates, in Pakistan, mental illness ratio is higher in women than men (Minas, 2009), so the use of lady health workers for provision of mental health services to their fellow women can be very productive. Also, in Pakistan, there is a stigma of consulting male psychologists and psychiatrists for female patients, so the use of female lady health workers can help to address this issue. Pakistan is already having a system of door to door medical services, for instance, polio vaccination, so a little extra training in mental health service to these door to door service teams, can considerably help to identify mental health cases for referral to mental health professionals.

## Conclusion

There is a need to collaborate with the stakeholders for provision of effective mental health service delivery in LAMIC (Ansari, 2015). Although the presented studies above are silent about the effectiveness of religious and faith healers in terms of mental health outcomes, their importance and the role they play in the Muslim societies cannot be denied. In view of the strong tendency of the people to believe in religious/faith based healers, there is a dire need to develop effective collaborations and partnerships between such leaders and medical practitioners. Traditional healers can be educated to refer the mental health patients to medical practitioners if traditional interventions are not initially effective, and, in return, medical practitioners can learn from the therapeutic, spiritual or other indications for referring their patients to religious/faith leaders (Schoonover et al., 2014). However, this would need a strong legislation and networking from the government in Pakistan.

On the other hand, as the research advocates, community and lady health workers, have always delivered great results for provision of mental health services with little extra training. Community health workers provide a strong link between the health system and communities, especially in developing countries where communities are geographically dispersed, have poor access to health facilities, have low literacy and high poverty rates and have no access to information related to prevention, control and treatment of disease (Mishra, Neupane, Preen, Kallestrup, & Perry, 2015).

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The authors have declared that no competing interests exist.

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