ODS I
University of Bern

MENTAL HEALTH AND CONFLICTS[1]

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[1] The topic was taken from the WHO & WGB joint panel Committee at ZUMUN 2018 in Zurich.

Introduction to the Committee

The World Health Organization (WHO) is a specialized agency within the United Nations system aiming to build a better, healthier future for people all over the world. Its priorities include enabling countries to sustain or expand access to all needed health services and financial protection, promoting global health coverage, addressing unfinished and future health challenges, promoting health outcomes and reducing health inequalities within and between countries. In recent years, WHO strives especially to address the challenge of noncommunicable diseases and mental health, violence and injuries and disabilities. WHO is also responsible for the World Health Report which is published regularly to provide policymakers, international organizations with the information about health policy and funding decisions. [2]

The World Bank Group (WBG) is a group of 5 institutions with the ambition to end extreme poverty and promote shared prosperity by 2030. Founded in 1944, the International Bank for Reconstruction and Development - soon called the World Bank - has expanded to the world's largest development institution. Today, World Bank Group's work touches nearly every sector that is important to fighting poverty, supporting economic growth and ensuring sustainable development. On critical issues like climate change, pandemics and forced migration, the WBG plays a leading role because it is able to convene discussion among its country members and a wide array of partners.[3]

In 2016, the WBG and the WHO co-hosted a two-day joint panel during the World Bank-International Monetary Fund Spring Meetings, aiming to move mental health from the margins to the mainstream of the global development agenda.

Agenda: 'Out of the Shadows: Making Mental Health a Global Priority

Mental disorders, such as depression, anxiety, and substance use disorders, impose an enormous global disease burden that leads to premature mortality and affects functioning and quality of life. If left untreated, mental disorders can result in worse treatment adherence and outcomes for commonly co-occurring diseases, such as tuberculosis, diabetes, cardiovascular disease, and cancer. Yet parity between mental and physical health conditions remains a distant ideal. Poor mental health also impacts on economic development through lost production and consumption opportunities at both the individual and societal level. It is estimated that the lost economic output caused by untreated mental disorders as a result of diminished productivity at work, reduced rates of labor participation, foregone tax receipts, and increased welfare payments amounts to more than 10 billion days of lost work annually – the equivalent of US$1 trillion per year.

Countries are not prepared to deal with this often "invisible" and often-ignored challenge. Despite its enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, or fear of disclosure because a job may be lost, social standing ruined, or simply because health and social support services are not available or are out of reach for the afflicted and their families. In spite of these challenges, there is growing support to move mental health from the periphery to the center of the global health and development agenda. As highlighted in WHO's Mental Health Action Plan 2013-2020, a

[2] http://www.who.int/about/what-we-do/global-guardian-of-public-health.pdf?ua=1

[3] https://www.who.int/mental_health/advocacy/WB_event_2016/en/

number of evidence-based, inter-sectoral strategies have been effective in promoting, protecting and restoring mental health, well beyond the institutionalization approaches of the past. Properly implemented, these interventions represent "best buys" for any society, with significant returns in terms of health and economic gains.

To fully realize the goal of universal health coverage across the world, it is critical to integrate prevention, treatment and care services for mental health disorders, along with psychosocial support mechanisms, into accessible service delivery and financial protection programs. Additionally, health and policy leaders need to identify "entry points" across sectors to help tackle the social and economic factors that contribute to the onset and perpetuation of mental health disorders.

World Bank-WHO Initiative [4]

To highlight the scale of these issues, and the gains from addressing them, the World Bank Group and WHO co-hosted the "Out of the Shadows: Making Mental Health a Global Priority" event as part of the WBG-IMF Spring Meetings held in Washington, D.C. in April, 2016. This event aimed to put the mental health agenda at the center of global health and development priorities by spurring efforts to: increase awareness about mental health as a development challenge and the associated economic and social costs of inaction; debate the economic and social benefits of investing in mental health; and identify ways for stakeholders to act across sectors.

Key Policy Actions

Mental health matters: Visibly increase the attention given to mental disorders at the national and international levels (including migration and humanitarian aid; social inclusion and poverty reduction; and human rights protection and universal health coverage). Strong leadership is needed to make mental health a priority, to commit to innovative and quality services, to channel resources toward mental health systems, and to strengthen community services.

Mental health works: Introduce or strengthen programs that promote and protect mental well-being into general health services (integrated care), school curricula (life skills), and occupational health schemes (wellness at work); and promote better coordination across these platforms and sectors.

Mental health needs: Devote additional resources from development assistance donors and domestic health budgets towards implementing community-based mental-health programs and strengthening the overall treatment of mental disorders as part of the progressive realization of universal health coverage.

There is still a long way to go to promote investment, resources, and accountability in the mental health sector. Next steps include enhanced international cooperation; the creation of private–public partnerships, specifically with technology companies; integration of mental health into other health and development sectors; and exploration of alternate models of mental health financing, such as the dedicated use of revenue from higher taxes on tobacco and alcohol. Each sector must keep the momentum going, and it is only by increasing collaboration and resources to make mental health a global development priority that progress will be made.

[4] http://www.worldbank.org/en/topic/mental-health

TOPIC: Mental Health and Conflicts

Addressing mental health is gradually being recognized as an important development issue, especially in the case of conflict-affected countries. Although mental health issues have received increased attention in post-conflict settings, there has been a tendency to implicitly assume that the impact of trauma caused by mass violence (i) may be transitory and nondisabling, and (ii) that interventions in the emergency phase are sufficient. However, a small but growing body of research on factors affecting mental health and effective treatment in post conflict settings casts doubts on both assumptions.

Current research suggests that major depression and Post-Traumatic Stress Disorder (PTSD) are prevalent and chronic among refugee and displaced populations. Research also shows that the impact of trauma is long term. Child survivors of Nazi holocaust and Japanese concentration camps were found to experience PTSD symptoms as late as 40-50 years following their traumatic experience. Some researchers postulate that these 'invisible wounds' can leave a society vulnerable to a recurrence of violence. Studies on Nazi Holocaust and Cambodian Pol Pot survivors show that their children and their children's children are also affected by the psychosocial impact of conflict.[5]

This topic argues that failure to address mental health and psychosocial disorders in populations that have experienced mass violence and trauma caused by conflict will impede efforts to enhance social capital, promote human development and reduce poverty. It argues that interventions dealing with mental health are both desirable and feasible, in order to support post-conflict recovery, the consolidation of peace and reconciliation, and the transition to sustainable development and poverty reduction. Support for mental health in conflict-affected societies can thus make an important contribution to meeting the Development Goals.

Mental and Psychosocial Disorders in Conflict Settings

In every population, 1-3% have a psychiatric disorder. Where conflict is present, the number may increase due to PTSD, alcoholism/drug abuse and depression arising from conflict-related stress. A further group, maybe 30-40% of the population, may experience symptoms such as sleeplessness, irritability, hopelessness and hypervigilance – symptoms which can persist and become more severe, thus interfering with the normal functioning of individuals.[6] This group is not classified as having a psychiatric disorder but may have psychosocial disorders manifested as domestic violence, criminal activities, school dropouts and other anti-social behavior. Lastly, following a traumatic event a large part of the population may suffer nightmares, anxiety, and other symptoms of stress, but these are often transient and will decrease in intensity and frequency over time.

At the core of every conflict is insecurity. This insecurity fractures social ties, breaks up families and

[5] http://www.nbcnews.com/id/35082451/ns/health-mental_health/t/most-holocaust-survivors-battledepression/

[6] http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/MentalHealthConfBaingana.pdf

communities, and displaces populations. The total number of refugees and internally displaced people is estimated at 37 million worldwide. Insecurity and displacement causes the breakdown of social services such as health and education. The stateless and displaced are unable to work in their fields or engage in productive activities, and weak or absent social safety nets there is a slide into poverty or dependence on humanitarian assistance. In addition, traumatic experiences directly related to conflict, often involving the loss of family members, participation in or witnessing of violent acts, cause further distress.

Although conflict is associated with an increase in the prevalence of mental disorders, there are few population based studies carried out among adults in conflict-affected areas and low-income countries.[7]

1. Among refugees, it is estimated that acute clinical depression and PTSD range between 40-70%. Epidemiological studies among IDPs and refugees on the Thai-Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate that 15 to 53% suffer from PTSD as a consequence of conflict. In Uganda, 71% reported major depressive disorder, and in Algeria, Cambodia, Ethiopia, and Gaza, psychopathology prevalence was 17% among non-traumatized against 44% for those who experienced violence. These estimates compare with less than 10% in non-conflict countries – in the U.S, less than 10% of the adult population will experience PTSD or major depression in a year (US Department of Health and Human Services, 1999). A study in Somaliland over a decade after the conflict found that one in five families was caring for at least one family member with severe mental problems, most were former fighters, and in virtually all cases, they had abused khat (a local plant containing an amphetamine). The study also found that 15% of former fighters suffer from a severe mental disorder (mostly psychosis), they are four times more likely to suffer from this severe incapacitating mental disorder than the already high prevalence in the general population, and combatants are two times more likely to be affected than civilian war survivors.
2. Overall, we can expect that the prevalence among the general population in a typical post-conflict country lies somewhere between the high rates found among refugees and the low rates in non-conflict countries.

A Conceptual Framework for Mental Health Programs in Conflict-affected Countries

Recognizing the importance of the linkages between poverty, conflict, mental and psychosocial well-being is not enough. It is also important to demonstrate that there are interventions that can address this dysfunction, that these interventions are feasible in post-conflict settings, that they will lead to increased productivity of those who are treated, and that they are cost-effective. Moreover, psychosocial interventions may contribute to peace and reconciliation by dealing with the anger, depression, and sense of hopelessness and helplessness suffered by victims of violence and insecurity. More research and development of good practices are clearly needed, but observations of experiences in mental health interventions can already provide some guidance on dimensions that must be addressed.

A model for mental health and psychosocial interventions needs to consider three basic dimensions: cross-sectoral, level of care, and coordination among policies and stakeholders.

[7] http://pubdocs.worldbank.org/en/728101481211075256/Mental-health-among-displaced-people-and-refugees-pmarquez-version-december-8-2016.pdf

A) The first dimension relates to the recognition that mental health care is multi-sectoral. The sectors involved include health, education, social welfare, refugee and displaced persons' welfare, and legal and judiciary sectors. There is great potential for interventions in the educational sector, within schools, to train teachers to recognize distress in children, provide initial interventions, and refer those who require specialized attention. The school setting provides an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation in the curricula.

B) The second dimension relates to the three levels at which care and interventions can take place. At the primary level interventions range from listening and support provided by members of family and the community, to programs in school and community centers, to support provided by primary health care providers. More specialized care is provided at the secondary level, through provincial and district hospitals, as well as outreach and support to primary care provider (PCP) centers and workers. Secondary level care can include play therapy, expressive art therapy, drama, and counseling support provided in a more structured environment than the primary level, often by NGOs. Such interventions may also be integrated into school programs. At the tertiary level is hospital-based mental health care with specialized personnel, diagnostic and treatment facilities, and psychosocial care such as residential transition and rehabilitation centers for war trauma survivors. Care at this level takes the form of specialized interventions such as group therapy and intensive individual therapy. There is a need for complementarity in the provision of these services as well as referral up and down the system. Each of the levels of care is crucial to successful implementation of interventions.

C) The third dimension refers to the need to coordinate and ensure consistency among components—policy, referral, supervision, and monitoring and evaluation—and stakeholders. The latter include the government, donors, non-governmental organizations, private providers, and UN agencies. Illustrations and experiences of interventions are drawn below from the West Bank and Gaza, Bosnia, Burundi, and Uganda.

Early child development and cross-sectoral collaboration

The Bank-supported Burundi Social Action Project included a community-driven Early Child Development component, covering cognitive development, health, nutrition and psychosocial elements. Local psychologists assessed the knowledge and literacy of mothers in participating villages and on this basis developed a training package, including a training-oftrainers manual, teacher handbook and educational aids. Following discussions and consultations with the Education Ministry and key representatives of NGOs and early child education, the training package is being piloted. [8]

Psychosocial programming in Uganda

The case of Uganda provides a good example of effective inter-agency collaboration and local planning. An initial assessment of the impact of conflict in Northern Uganda, supported by UNICEF, was carried out by the Ministries of Health and of Gender, Labor and Social Development, and five NGOs working

[8] http://pubdocs.worldbank.org/en/728101481211075256/Mental-health-among-displaced-people-and-refugees-pmarquez-version-december-8-2016.pdf

on psychosocial issues. The results were disseminated to each district in separate workshops, designed to assist participants plan psychosocial interventions relevant for their districts. Results include: district multi-sectoral psychosocial plans; improved national, regional and district coordination on psychosocial issues; standardization of counseling provision and training; improved coordination, sharing of resources and advocacy work among NGOs; and guidelines on district-level monitoring and research of affected populations.

Conclusion

Experience to date indicates that it is possible to cost effectively implement mental health and psychosocial programs in different sectors and with very different approaches. In all interventions, there is a need for collaboration within the health sector, between primary health care and mental health, but also with other sectors outside of health. Coordination between the Government, NGOs and the private sector is also vital to the success of mental health and psychosocial programming. The major challenge to mental health and psychosocial programming remains the lack of documentation on the evaluation of programs. These would provide process, outcome and impact indicators that would be useful for scaling up or replication. As part of the committee we urge the delegates to think on:

1. Ways of making mental health care more accessible, affordable;
2. How can the world be more pro-active in solving for ‘mental health’ problems across all age groups, gender and countries?

Additional Research Material

1. Here you will find basic information concerning the mental health system, governance and promotion of your country:

   The Mental Health Atlas 2014- http://www.who.int/mental_health/evidence/atlas/profiles-2014/en/

2. The Mental Health Action Plan 2013-2020 provides thorough and comprehensive information about the commitment of the WHO to addressing mental health issues.

   Mental Health Action Plan 2013-2020 http://www.who.int/mental_health/action_plan_2013/en/

3. This is the resolution WHA65.4 adopted by The Sixty-fifth World Health Assembly.

   Comprehensive mental health action plan 2013-2020
   http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_R8-en.pdf?ua=1

4. Ten facts on mental health
   http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/

5. Here you can find all information about innovative programs for a better mental health situation:

   Mental Health Innovation Network http://www.mhinnovation.net

6. Ten Years in Public Health 2007-2017

   Page 109 to 110 marks particularly the road of how mental health problems are brought from marginal agenda to global priority http://www.who.int/publications/10-year-review/dg-letter/en/

7. Background Paper: Out of the Shadows: Making Mental Health a Global Priority
   http://www.who.int/mental_health/advocacy/wb_background_paper.pdf