AMRO

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HUMAN HEALTH AND GLOBAL CONFLICT

INTRODUCTION

The AMRO region is a region heavily affected by human conflict. Countries in the AMRO region include Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States, Uruguay, and Venezuela. Many countries are facing political turmoil, gang violence, and large numbers of immigrants and emigrants. Human conflict leads to a variety of problems for the people who experience it, and has an especially strong impact on mental health. Not only does human conflict cause violence and physical harm to the people experiencing it, but the trauma of experiencing such a situation can last for a person's entire lifetime, even if they are able to escape the situation that caused it. According to the World Health Organization, approximately twenty-two percent of people who live in areas affected by conflict will develop mental health disorders as a result.[23] This can be related to many factors those affected by human conflict face, including, but not limited to, food or housing insecurity, exposure to violence, and forced migration.[21] While mental health disorders are not exclusive to conflict-affect populations, studies show that common mental health disorders, such as anxiety and depression, more than double during times of conflict.[23]

The presence of violent conflict directly correlates to the degradation of mental health in a population. Violence, trauma, and stress are all outcomes of warfare and armed conflict and impact not only the physical wellbeing of society, but also the psychological state of the community facing the crisis. Victims of conflict are often innocent bystanders that feel helpless and hopeless in their current situation. According to the World Health Organization, about one of five people living in an area of conflict develop mild depression, anxiety, or psychosis. Additionally, one in ten people live with a moderate to severe mental disorder.[23] In addition to victims of conflict, soldiers involved in violent conflict experience trauma and stress during deployment that can lead to the development of mental disorders. In the United States, the National Institute of Mental Health was established as a result of the disasters of World War I and World War II, which sheds light on how deeply warfare and violence disturbed the mental health of Americans. Based on a 2014 study, approximately one out of four active duty members in the U.S. developed mental illness including post-traumatic stress disorder, depression, and traumatic brain injury.[1] While these trends are seen in the United States, it is safe to assume that these trends are reflected worldwide. Warfare and conflict as a whole remain large contributors to the development of mental illnesses. However, many times, access or willingness to receive mental health treatment remains sparse. Around the world, approximately 40-60% of military personnel suffering from mental health issues and those who could benefit from professional treatment, do not seek help due to cultural barriers such as stigma and economic barriers including cost of mental health treatment services.[22] For other victims of war, access to professional personnel in conflict zones remains scarce and often is not catered to specific needs but is rather designed as a generic approach.

The global community has worked to help enhance access to mental health services for victims of conflict. The Inter-Agency Standing Committee (IASC) was created in 1991 to help strengthen humanitarian action globally. [20] In 2007, IASC introduced the "Guidelines on Mental Health and Psychosocial Support in Emergency Settings" which intended to create a more structured response towards mental health in conflict zones. The guidelines focus on identifying marginalized populations

within conflict zones and determining their holistic needs while also addressing the mental health needs of the community as a whole. While the guidelines have been useful, they still remain only a framework. Funding and changes in practice and culture towards the treatment of mental illnesses and disorders still continue to be priorities while addressing the mental health of victims of conflict.[20]

MENTAL AND EMOTIONAL WELL-BEING

CASE STUDY #1

In 2017, the World Health Organization put out a survey regarding two psychiatric illnesses that are highly prevalent all around the world: depressive and anxiety disorders. The results of that survey revealed that Brazil leads in the world in terms of anxiety cases and is fifth in terms of depression cases.[5] Individuals in Brazil place high importance on socioeconomic status and appearance, leading many Brazilians to hide their troubles and not seek mental care. Traditionally, Brazilian culture values individuals who work constantly and take long shifts, placing an increased burden on their mental health. Long hours cause individuals to disregard other activities that take their mind off of the stress. Fortunately, Brazil has a mental health service system called The Psychosocial Community Centers (CAPS) that offers care and resources to those with persistent mental health issues. However, CAPS is still small and is not distributed evenly across Brazil due to a lack of funding (the Brazilian government spending only 2.4% of the total mental health budget).[7]

Stigma is the negative attitudes or discrimination against someone based on one or more distinguishing characteristics.[3] At the root of Brazil's great mental health crisis are individuals' stigma towards mental disorders, not only in the general population, but also in healthcare workers. One study surveyed 779 psychiatrists addressing four different dimensions of stigma regarding a patient with either schizophrenia or ADHD. The four dimensions were about restrictions on civil rights, stereotyping, perceived prejudice, and social distance/interaction. After the data was collected, researchers split the responses into three different subgroups of stigma levels - high, intermediate and low. The results showed us that over 50% of psychiatrists surveyed held the highest stigma regarding individuals with schizophrenia. Mental health prevalence and the lack of resources stems from the deep rooted traditional beliefs that Brazilians hold.[9]

Stigma is shared across cultures and is incorporated in every aspect of life, they are difficult to tear apart and are established over many years. Mental health stigma is the shame that society places on people who live with a mental illness.[6] This stigma comes from stereotypes that are inaccurate and offensive. A lack of education and a fear of people with mental illness can lead to an increase in stigma. Stigma can make a person living with a mental health condition make it hard to recover, social isolation, low self-esteem, and shame. By educating, societies can diffuse mental health stigma.[3] An effective approach of destigmatizing mental health will allow advances in economic, social, education, and political spheres.[3] Mental health affects how we feel, think, and act through our days and in turn affects how we treat the people around us.

CASE STUDY #2

In the United States of America, mental health is becoming more and more prevalent with millions of people being affected each year. While Americans are gaining more access to treatment and resources, the rates of mental illnesses have not seen a significant decline. More than 50% of all people in the United States will be diagnosed with a mental illness at some point.[4] Mental health has always been treated differently in the US, we could go back in time and see gender-biased witch hunts, unkempt mental asylums and electroshock treatments. Those who are not living the "standard" level of life are

treated differently. In 44 states, jails or prisons hold more mentally ill individuals than the state's largest remaining psychiatric hospitals. Mental illnesses are so prevalent in jails and prisons that they are now called the "new asylums". 64% of jail inmates, 54% of state prisoners, and 45% of federal prisoners are reporting mental health concerns.[1]

The United States had a relatively stable prison population until the late 1960s and early 1970s when there were rising concerns over cocaine and other drugs. This caused many drastic laws and policies to be implemented and resulted in close to 13 million people being in jail annually.[1] While in incarceration, prisoners are faced with stress, isolation, and many other negative effects. Studies show that those with incarceration history have a significantly higher likelihood of depression, dissatisfaction, mood disorders, and anxiety disorders.[8] With the rise of U.S. incarceration over the past years, the social and mental impact needs to be discussed. Almost 1 in every 100 people in the United States are incarcerated.[8] According to one study, fathers in prison, compared with not incarcerated fathers, had higher odds of depression (39.1% vs 20.6%), higher drug usage (34.8% vs 10.3%), and higher alcohol consumption (21.7% vs 8.8%). The study is regarding fathers, causing a large impact on the families and children of the incarcerated.[8]

Addressing the mental health of the prisoners will only benefit the community as a whole because it decreases the incidents of re-offending, reduces the number of people returning to prison, and ultimately reduces the high cost of prison upkeep.[2] Not only is holding mentally ill inmates costly, but they will also create behavioral management problems that will hurt themselves and others. Mental and emotional health should be addressed no matter the social status of the individual and the location. Mental health impacts emotions, thoughts, actions and can appear anytime throughout a lifetime. The United States needs a system that caters to all populations without taking into consideration their background to treat everyone respectfully and fairly.

CASE STUDY #3

The effects of violence and conflict relating to the power struggle in Venezuela has led to many families being forced to seek refuge in surrounding countries. This, combined with severe inflation and food shortages has made looking after one's health in Venezuela very difficult, especially mental health.[13] This means that this crisis not only affects Venezuela, but countries that are the recipients of these migrants as well. Countries like Brazil, Argentina, Chile, Ecuador, Mexico, Panama, and Peru have allowed for Venezuelan refugees to enter, but are stretched beyond capacity.[13] Of the problems these refugees face, mental health is often the most overlooked. Countries and humanitarian aid groups tend to focus on providing shelter, clothing, and food, and have little to no resources left over to focus on mental health.

Many factors, like poverty, food insecurity, homelessness, and risk of violence, are very prevalent in the pre-migration lives of many Venezuelan migrants and have been linked with an increase in common mental health disorders.[10] Because many of the migrants fleeing Venezuela are being displaced, they are much more likely to have experienced these factors or other forms of trauma than migrants who voluntarily leave in search of economic opportunities.[12] Additionally, after and during migration, forced migrants face issues such as social exclusion, language difficulties, and extreme stress, which can also contribute to deteriorating mental health.[11] Besides the immediate effects, living through traumatic events, especially for refugees, often leads to transgenerational trauma, affecting future generations as well.

Because of the refugee status of these migrants, there is little that receiving countries can do to remedy this situation, especially considering their limited budgets. So, much of the responsibility to remedy this situation falls to NGOs, humanitarian aid groups, and individuals. The Regional Inter-Agency Coordination Platform for the Venezuela situation, an international organization aiming to assist governments in the integration of Venezuelan refugees, has been the most influential of these groups, providing a specific plan for groups wishing to help, and directing those who wish to help in order to maximize their efficiency. This plan, called the Regional Response Plan for Refugees and Migrants from Venezuela, targets the specific causes that can worsen a refugee's mental health, and focuses on social and economic integration in host communities.[13] Currently, this plan, partnered with humanitarian aid from the EU and the US is the most prominent solution to this crisis, but it is limited by a lack of funds. In order to help remedy this crisis, more humanitarian aid is required, and it must target the root of the problems that Venezuelan refugees face, instead of simply treating the surface level problems.

PUBLIC HEALTH INSTITUTIONS AND INFRASTRUCTURE

CASE STUDY #1

Worldwide, mental healthcare is highly inaccessible. In Mexico in particular, a large percentage of the population suffering from mental health disorders do not receive the necessary treatment due to the inaccessibility. The estimated care gap is between 78.1% and 81.4% due to geographical, social, financial and cultural barriers to accessing mental health care.[14] Making sure individuals get the necessary access to mental healthcare will reduce or eliminate the risk of suicide, legal issues, family conflict, or employment issues. The results of the Mexico National Comorbidity Survey, part of WHO's World Mental Health Survey Initiative, states that fewer than one in five respondents with a 12 month prevalence of a psychiatric disorder used any service during the previous year and only one in every two respondents who used services received care that met even the minimal standard for adequacy.[14]

In Jalisco, Mexico, the community mental health care model was created and implemented to improve the situation. An EvaRedCom - TMS instrument was used to provide an evaluation for geographic and economic accessibility through different regions of the state including rural and urban communities. From the results, it was found that Jalisco offered a total of 31 centers with an average of 0.64 mental healthcare workers for every 10,000 inhabitants who are over 15 years old. The global rate of mental health workforce is 9.0 for every 100,000 inhabitants while the mental health workforce rate in Jalisco ranges from 0.13/10,000 to 1.84/10,000 in the more populated areas showing that the mental health workforce in Jalisco is well below the global rate. On top of that, it takes anywhere from 30 - 172.7 minutes with a transportation cost of 22.3 USD to reach the center. [15]

There are multiple barriers to access mental health networks and its care (unfavorable number of resources, long distances, and high costs). Identifying the mental health network deficiencies is the first step towards establishing a better community mental health care model within the country. Improvement of mental healthcare in Mexico is urgently needed and should not depend only on the sparsely available resources. Some ways mental healthcare can be more readily available is by active outreach, reallocation of services and providers, and employee brief screens that are needed to accurately identify mental disorders.

CASE STUDY #2

On January 12, 2010, an earthquake in Haiti killed over 222,000 people, injured over 300,500, and left 1.5 million others without a home.[18] Due to this dramatic and drastic event, the mental health of individuals across the country were monumentally affected. Nearly all Haitians reported some symptoms of having PTSD or a major depressive disorder even after as far as 30 months after the earthquake.[18] Trauma exposure is evident throughout all age groups in Haiti and in order to create a mental health system that functions adequately, it is important to understand the severe experience with trauma they have had. However, even prior to the earthquake, a formalized mental healthcare system did not exist. Another thing to consider is that Haitians preferred to seek mental health care through community care - religious leaders and traditional healers - rather than through clinical.[18]

A month after the earthquake, the Minister of Health in Haiti asked Partners in Health (PIH) and Zanmi Lasante (ZL), non-governmental health care delivery organizations, to support the government in developing a system that aids the Haitian population with mental health services. The ZL and the PIH both worked to come up with sustained and community based mental health care. Improving treatments, expanding access to care, integrating screen and services into primary care, developing treatment for use by non-specialist providers, and improving access to medications/reducing costs all existed in their plans. PIH and ZL were able to demonstrate that through adequate preparation and research at both the macro and micro levels, there are ways to establish adequate mental healthcare infrastructure. With the existence of electronic health records, the study was able to improve the quality of clinical care and increased utility for other research purposes that all aid Haiti. Through detailed planning, partnerships, teamwork, patience and tenacity, both teams were able to have a significant impact on the way mental health care services are going to be provided all over the world.[19]

Ongoing stressors that were occurring for the Haitian residents include unemployment, food insecurity, minimal education access, and political unrest. These inconveniences are only reinforced through the COVID-19 pandemic. The uneasy circumstances are experiencing malnourishment, psychological distress, gang violence, kidnappings, and so much more. The pandemic proves how important sustainable mental health services are. With proper mental health services, individuals are able to aid the development of society as a whole by improving productivity of business, allowing children to get education, and disable other community disruptions. Unaddressed mental health problems will only reinforce the problems that Haitian residents are currently facing.[18]

CASE STUDY #3

Canada's accessibility to mental health care has been constrained by gaps in insurance coverage and funding. Only 5 -7 % of funding is spent on health services. On account of this, half of Canadians experiencing a major depressive episode receive "potentially adequate care." 75% of children with mental disorders do not have access to specialized treatment services. Mental health services that are provided directly from general practitioners are able to be billed to health insurance plans but services provided by any non-physician providers cannot. This leads to almost 1/3 of Canadians to seek care through publicly funded clinics or pay out-of-pocket. With the large financial burden these costs pose, it is not surprising that Canadians put mental health on the backburner. Government action on mental health could lead to decreased stigma towards mental health and make more services accessible.[16]
In order to adequately provide for all populations in Canada, access to mental health services has to be equally distributed through all class levels. There is a clear divide between the accessibility and mental

health levels of those who are richer vs poorer. The results from the study confirm the income difference from mental health distribution. More of the richer individuals use health services provided by non-physicians and are more equitable for general practitioners but not for social workers, nurses, and psychiatrists. Despite these variations, greater inequities in unmet need for mental health care than for physical health care suggest that inequity is the dominant reality for Canadians. The results provide a baseline that could be used to assess the equity impacts of policy reforms.[17]

Mental illness affects more than 20 percent of the Canadian population yet the mental health care services are not funded enough to aid in reducing its population. Because of its highly stigmatized nature, mental illness is deemed too expensive because of prevalence and is not given enough priority.[16] Canada is the only country with a universal health care system that does not include universal drug coverage. While increasing the funding that the Canadian healthcare system receive can be beneficial, altering the way the funding is invested can also be a smart move. Generations of Canadians are faced with gaps and inequities in mental health services, but now that funding is declared as the issue, there is potential to find a solution and close the gaps.

CONCLUSION

To be in good health is not just limited to the physical connotations, rather includes the mental health of the individual. Countless people suffer from mental health illnesses and suffer from a lesser life quality. Mental health is often overlooked in the AMRO region due to societal standards and stigmas. The mental health treatment gap in the AMRO region is a public health priority due to a large proportion of adults being left untreated. Resources are still insufficient to meet the growing burden of mental illness and are severely unevenly distributed. Existing services must be transformed to increase coverage and improve accessibility to mental health care and to ensure that mental health is something that is valued in society. Receiving the necessary mental health treatment is the most important thing that can be done for the individual. Mental illness should not be thought of in a negative light or as something to be ashamed of. While progress is being made - resources and services are slowly being shifted from psychiatric hospitals to community services - there is still much to do.

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