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THE WORLD BANK

Mental Health and the Global Development Agenda: What Role for the World Bank?

Proceedings of a November 2003 Seminar and an Overview of World Bank Interventions in Mental Health

MENTAL HEALTH AND THE GLOBAL DEVELOPMENT AGENDA: WHAT ROLE FOR THE WORLD BANK?

August 2004

Mental Health and Its Impact on the Global Development Agenda: How Should the Word Bank Respond?
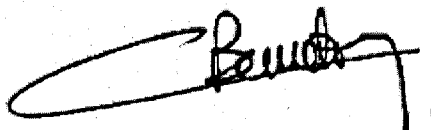
FOREWORD

When the first Burden of Disease estimates were reported in 1990, a surprising finding emerged to the effect that "the burden of psychiatric conditions [had] been heavily underestimated" (Murray and Lopez). At that time, neuropsychiatric disorders were estimated at 6.8% of total DALYs lost. The 2003 WHO Report now estimates that neuropsychiatric disorders make up 13% of total DALYs lost, an increase far higher than projected in 1990.

The World Bank has been engaged in the area of mental health and its impact on development for the past five years. In November 2003, a Seminar was organized with the theme '*Mental Health and the Global Development Agenda: What Role for the World Bank?*' and was co-sponsored with the National Institutes of Health of the United States Government. This publication presents the proceedings from the Seminar in Section 1, and an overview of World Bank mental health activities in Section 2.

A key message that can be taken away from this report is the continuing need for further research on the costs and effectiveness of mental health interventions. In addition, as the proceedings made plain, models of best practice in implementing mental health programs should be documented and disseminated widely. Nonetheless, there are success stories to relay, for example, the Burundi Early Childhood Development Project, the Bosnia and Uganda Integrating Mental Health into Primary Health Care Case Studies, and various missions that have been carried out, together with their reports and strategies.

The demand from client countries is increasing and we now have evidence that mental health components can be effectively integrated into World Bank programs and projects. Toolkits to assist Task Managers working on Conflicts and on HIV/AIDS will shortly be available.

Sincerely,

Jacques Baudouy
Director
Health Nutrition and Population

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PREFACE

The Bank has long acknowledged the multiple dimensions of poverty. Poverty is related to income, lack of education, social exclusion, insecurity, vulnerability and ill health.

Although WHO defines health to include physical, mental, emotional and social dimensions, the concept of health is often restricted to physical conditions. Such conditions are more easily monitored and the related interventions are more easily evaluated. People with mental disorders experience considerable disability and resultant poverty that must also be addressed. Just as mental illness may lead to poverty, the stressors of poverty, including social exclusion, conflicts, and endemic physical disease, greatly increase rates of mental disorder. Thus any poverty reduction strategy must recognize the importance of mental health.

In order to review the past five years of engagement in the area of mental health, the World Bank organized a seminar with partner agencies to bring together practitioners and researchers equipped to share ideas on the successes and challenges of integrating mental health into World Bank activities. The seminar *Mental Health and the Global Development Agenda: What Role for the World Bank?* took place on November 24-25, 2003, at the World Bank Headquarters in Washington, D.C, and was co-sponsored by the World Bank and the National Institute of Mental Health. The proceedings were strengthened by the presence of the Minister of State for Health of Uganda and the Assistant Minister of Health and Social Welfare of the Sprska Republic of Bosnia and Herzegovina.

Participants at the seminar emphasized the importance of addressing mental health on a global scale. It was agreed that responding slowly or weakly to mental health issues or denying the imperative for a comprehensive approach will put other development efforts at risk.

By encouraging analysis and dialogue the seminar flushed out responses to some of the questions and issues identified during the sessions. The discussions enriched our common understanding of the tasks required to deal with global mental health issues, provided a stronger foundation for shared efforts, offered direction for further work that targets mental health, and clarified the future direction of the Bank in carrying mental health activities forward.

This document is divided into two sections. The first section presents the topics covered at the November 2003 seminar, specifically addressing the future role of the World Bank in the international mental health arena. The second half explores specific thematic areas related to mental health that must be addressed, and discusses how the Bank can build on what it and its partner organizations have already accomplished in these areas. The themes that will be addressed in the second section include conflict and post-conflict, early child development, mental health in primary health care, orphans and vulnerable children, HIV/AIDS, and violence against women.

To see video coverage of the seminar presentations, visit the World Bank's webcasting link at:
http://info.worldbank.org/etools/bspan/EventView.asp?EID=503presentations

ACKNOWLEDGEMENTS

SECTION ONE

WORLD BANK/ NATIONAL INSTITUTE OF MENTAL HEALTH SEMINAR PROCEEDINGS, NOVEMBER 24-25, 2003, WASHINGTON, D.C.

1. SEMINAR PROCEEDINGS OVERVIEW

The World Bank and the National Institute of Mental Health organized the seminar *Mental Health and the Global Development Agenda: What Role for the World Bank?* held November 24-25, 2003, at the World Bank Headquarters in Washington, D.C. The seminar was organized to review the five years of World Bank mental health projects and activities, identify existing challenges to mental health initiatives, and plan a strategy for strengthening the Bank's role in mental health. The objectives of the seminar were twofold and included (1) taking stock of the Bank's mental health projects since 1999, and (2) identifying lessons learned, good practices, challenges and gaps in global mental health programming in order to determine a future role for the Bank in the area of mental and neurological disorders.

The four themes for the seminar were (1) mental health programming for low and middle-income countries, (2) alcohol and public health, (3) mental health and early child development, and (4) mental health and conflicts. Over the course of the two days, two sessions were led on each theme. Presenters included:

Mental Health Programming for Low and Middle-Income Countries

- ❑ Captain Mike G. Mukula, Minister of State for Health, Uganda, "Integrating Mental Health into Public Health Care"

- ❑ Nedim Jaganjac, World Bank Consultant, Human Development Unit, ECA Region "Europe and Central Asia: Profile of Mental Health"

Alcohol and Public Health

- ❑ David Jernigan, Center on Alcohol Marketing and Youth, Georgetown University "Alcohol in Development and in Health and Social Policy"

- ❑ Dori Langevin, Project Director, Pacific Institute for Research and Evaluation "Alcohol and Drug Addiction Treatment in Russia"

Mental Health and Early Child Development

- ❑ Renee Bradley, U.S. Department of Education, Office of Special Education Programs "School-wide Positive Behavior Support"

- ❑ Potien Bikebako, Twitezimbere Director, Burundi "Twitezimbere: NGO from Burundi"

Mental Health and Conflicts

- ❑ Richard F. Mollica, Director of the Harvard Program in Refugee Trauma

"Harvard Program in Refugee Trauma"

❑ Dr Jovic Stevan, Assistant Minister of the Ministry of Health and Social Welfare of the Sprska Republic of Bosnia Herzegovina, "Mental Health in Bosnia Herzegovina"

2. PARTICIPANTS

The seminar brought together World Bank staff from the fields of social protection, education and health, as well as from the Development Economics (DEC) group, the Conflict Prevention and Reconstruction Unit (CPR) and the Disability Unit. Outside participants came from a variety of organizations, including the National Institute for Mental Health (NIMH), Fogarty International Center, the Center for Mental Health Services (CMHS), Mental Disability Rights International (MDRI), the Anxiety Support Organisation of South Africa, the Inter-American Development Bank, and the American Red Cross, among others. Several partner agencies participated in a panel discussion to share their perceptions of the Bank's role in the global development agenda.

Sessions were facilitated by World Bank staff including Jacques Baudouy, Director of Health, Nutrition and Population; Judy Heumann, Disability Advisor; Oey Meesook, HD Sector Director, Africa Region; and Ian Bannon, Conflict Prevention and Reconstruction (CPR).

3. ADDRESSING THE NEED FOR MENTAL HEALTH INITIATIVES

Jacques Baudouy, World Bank Director for Health, Nutrition and Population, launched the seminar with a session providing background information on the global mental health burden, the history of mental health activities at the Bank, the objectives of the seminar, and the overarching seminar themes. The floor was then opened for discussion.

3.1 The Global Mental Health Burden

According to the Global Burden of Disease study, mental and behavioral disorders constitute 12 percent of the global burden of disease[1] – a burden greater than either cancer or heart disease and larger than the burden of AIDS, tuberculosis and malaria combined. Though the latter three disorders have excited intense efforts toward reducing their 11.4 percent share of the burden, mental disorders are neglected by comparison. Some of the reasons for this neglect are:

(1) Getting accurate epidemiological data for mental and neurological disorders is difficult, especially for the developing world.

(2) Misperceptions about mental illness are common (i.e. mental disorders are not real illnesses and are not that disabling, there are no effective treatments for mental disorders, and treatments are too expensive).

(3) The cost of not intervening is not known. Data on country costs incurred as a result of mental and neurological disorders only now is starting to be understood (i.e. days absent from work, impact on education, impact on nutritional outcomes).

(4) A limited amount of information exists regarding cost-effective interventions for mental and neurological disorders in the developing world. For cash strapped governments with high adult and child mortality from infectious diseases, investing in programs that deal with these issues is

easier and more widely supported than investing in mental and neurological disorder programming where returns on investment are often less clear.

(5) Present practices center around supporting medical, hospital-based approaches which often are not cost-effective or accessible to the majority of the population.

(6) Governments prefer to put their scarce resources into service delivery rather than into determining the extent of the problem or piloting and documenting community-based approaches.

(7) Health is under-funded in the majority of developing countries.

The 2001 WHO Atlas of Mental Health Resources indicates that although 70 percent of the world's countries have mental health programs, 62 percent of low-income countries spend less than 1 percent of their national health budgets on mental health. Furthermore, though the majority of the world's mental health care financing is tax based (60.2%), out-of-pocket payments are the primary source of financing for 40 percent of low-income countries[a] as compared to 2.9 percent of countries with high incomes.[2] This reliance on individual responsibility for mental health care in areas with little disposable income places a substantial burden on the mentally ill and their families as they attempt to meet their health care needs.

The limited number of available mental health resources is another challenge for developing nations. While Europe has 8.7 psychiatric beds per 10,000 population, Africa and South-East Asia have only .34 and .33 beds per 10,000, respectively. The variance between regions is again great in regard to mental health personnel. Though Europe has 9.0 psychiatrists per 100,000 population, Africa (.05), the Western Pacific (.28) and the Americas (1.6) have dramatically fewer psychiatrists to meet their needs. Disparities between regions and income brackets are also common for psychiatric nurses, psychologists, and social workers functioning in mental health capacities.[3] Furthermore, of those resources that are available for mental health, most are poorly distributed, concentrated in large institutions that are not accessible to the majority of the population.

Figure 1: Definitions

Mental health: State of complete mental wellbeing, including social, spiritual, cognitive and emotional aspects. It is not merely the absence of disease or disorders.

Mental illness: Disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems such as the International Classification of Disorders, 10th Edition (ICD-10) or the American Psychiatric Association's Diagnostic and Statistical Manual, 4th Edition (DSM IV).

Psycho-social disorders: Interrelationship of psychological and social problems which together constitute the disorder. Psychological symptoms are those that have to do with thinking and emotions while social symptoms relate to the relationship of the individual with the family and society. Save the Children and UNICEF acknowledge an inherent relationship between psychosocial wellbeing and an individual's relationships, feelings, behavior and development.

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[a] Countries are categorized by World Bank (2000) determined income groups based on GNI per capita levels, with low-income countries at $755 USD or less per capita and high-income countries at $9,266 USD or more.

3.2 Non-biological Causes of Mental Disorders

Though many myths surround the origins of mental illness, it is now understood that mental illnesses are caused by an interaction of social, genetic, traumatic and infectious factors. Some of the non-biological causes are illustrated below.

AIDS/HIV: Sadness, fear, anger, anxiety, grief and depression are common elements of the process of coping with chronic illness and can have a strong impact on patients, their families and friends. In addition, HIV/AIDS patients and those close to them are often subjected to the social stigmas and discrimination associated with AIDS. Such factors can negatively impact the mental health of all involved, including orphaned children. The disease itself can also cause neurological deficits in patients such as progressive dementia, manic symptoms and atypical psychosis.

Conflicts: Conflicts lead to psycho-social consequences and an increase in the prevalence of mental disorders. 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 such trauma is long-term.[b] The mental disorders and psycho-social consequences associated with conflicts include anxiety, sleeplessness, fear, anger, aggressiveness, depression, flashbacks, alcohol abuse, suicide, and domestic and sexual violence.

Substance abuse: In addition to being a risk factor for victimization, misuse and/ or dependence on psychoactive substances is a form of mental disorder. It may also represent self-treatment for depression or anxiety. Substance abuse is on the rise in regions of the world such as former Soviet nations, especially among the male population.[4] Furthermore, even if they have no prior history of substance abuse, rates are elevated for women who have experienced violence.

Violence against women: According to the WHO's 2002 World Report on Violence and Health, between 10 and 69 percent of women from 48 surveys report having been physically assaulted by an intimate partner. Research shows that these women are significantly more at risk for depression, psychosomatic disorders, drug abuse and suicide.[5] Furthermore, psychologically devastating acts are frequently perpetrated against women during conflicts and as a result of ongoing customs like female genital mutilation (FGM) and child marriage.

Social Capital: Communities with poor social capital have higher rates of mental disorder and suicide. A variety of analyses have suggested a relationship between mental health and social capital. These studies have looked at suicide and anti-social behaviour, socialization and isolation, trust, participation and civic engagement, income disparities, and protection during crisis. When social cohesion is lacking it negatively affects mental health and, as a result, hinders both human and economic productivity.

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[b] For more information see: Florence Baingana and Ian Bannon, "Mental Health and Conflict," Social Development Notes: Conflict Prevention and Reconstruction, no. 13, ed. Sigrun Aasland, Washington: World Bank, October 2003.

3.3 History of Mental Health Activities at the World Bank

World Bank activities in mental health began long before there were formal mental health advisory positions. Since 1994 World Bank projects have incorporated mental health components in a number of fields including legal and judiciary reform, health and health sector reform, early child development, conflict and emergencies, social protection, and health systems development.

The 1993 World Development Report "Investing in Health" followed by the 1996 Global Burden of Disease study brought the need for increased focus on neuropsychiatric disorders to the foreground. Though mental health disorders account for four of the ten leading causes of global disability, at present they receive less than 1 percent of most national health budgets.[6] Meanwhile, the cost of failing to address mental health issues is increasingly apparent in that they account for 12 percent of the disease burden,[7] reduce national productivity, and push households into poverty. Furthermore, the epidemiological transition underway in developing countries has meant a growing proportion of the burden of disease results from non-communicable diseases. Consequently, the burden of disease from mental disorders is on the rise.

Shortly after a September 1998 seminar delving into mental health in the developing world, the World Bank agreed to create a Mental Health Specialist position within its Health, Nutrition and Population Unit. The position was filled in 1999 by Harvey Whiteford, former Commonwealth Director of Mental Health in Australia. In 2000 the one year position was extended for another two years and Florence Baingana, a Principle Medical Officer from Uganda's Ministry of Health, accepted Dr. Whiteford's position as he took on the role of part-time mental health consultant for the Bank. The John D. and Catherine T. MacArthur Foundation and the World Federation for Mental Health supported the Mental Health staff for the first three years of their work. The National Institute of Mental Health and the Center for Mental Health Services then provided the necessary support for an additional year and a half.

The key objectives of these positions are to:

1. Generate and/or compile knowledge on mental health through analytic work;
2. Disseminate this knowledge within the Bank and to the Bank's clients;
3. Provide policy, technical advice and develop tools that facilitate the integration of mental health components into Country Assistance Strategies, Poverty Reduction Strategies and Poverty Reduction Support Credit as well as other Bank lending and non lending instruments;
4. Build partnerships with WHO, UNIFEM and other UN and bilateral agencies, as well as global mental health NGOs.

Mental health was included in the July 2002 Health, Nutrition and Population (HNP) Survey as part of the regular monitoring of mental health activities and to enhance client responsiveness. The yearly survey seeks to determine the performance of the HNP Division in its relationship to the rest of the Bank. Its mental health component addressed whether mental health was considered important to the Bank's activities. The survey sought to evaluate what had been useful in past mental health interventions in order to determine a future focus. Overall, the assessment of mental health activities was positive, and mental health was recognized as an area that has been marginalized, and about which more information is needed, especially in the areas of HIV/AIDS, alcohol and conflicts.

3.4 Opening Discussion Highlights

The dialogue following the opening session foreshadowed issues that ensuing sessions would examine in greater depth. Jacques Baudouy initiated the discussion, stressing three main topics to be addressed during the seminar:

1. The need for a convincing argument for the Bank's involvement in mental health;
2. Defining what a convincing response to mental health would be, including what the best practice is, how much it costs and what the cost-benefit is;
3. Determining what the Bank's comparative advantage is and what its level of involvement should be, taking into consideration other stakeholders such as UN agencies.

According to Dr. Baudouy, though mental health has become increasingly important for the global agenda, it is still often overlooked. As of yet, the Bank's engagement in mental health activities has been very limited and he wondered if, as a result, fundamental issues related to mental health have been missed. Though mental health is linked to other critical areas such as HIV/AIDS, conflict, violence against women, traffic accidents, and alcohol and drug abuse, it has not been explicitly mentioned as a Millennium Development Goal (MDG) and has not been addressed within the relevant MDGs.

Dr. Baudouy argued that the challenge of integrating a new issue into the Bank's agenda is that the demand for change has to come from the client countries themselves. When the key country decision makers are in the Ministry of Finance and not the Ministry of Health, however, health concerns may be viewed as secondary to other national problems. Furthermore, within the Bank itself task managers sometimes have to be convinced of the need to integrate the new issues. Dr. Baudouy also stressed the importance of thoroughly understanding the cost requirements of such changes since middle-income scenarios are likely to be very different from low-income scenarios.

A seminar participant from the World Bank raised the issue that there is currently a widespread lack of data regarding global mental health. Another participant responded, explaining that quantitative and qualitative research on mental health has not been a high priority due to a lack of funding. During the course of the seminar this gap developed into one possible aspect of the World Bank's future role in mental health.

SEMINAR SESSIONS

4. MENTAL HEALTH PROGRAMMING FOR LOW AND MIDDLE INCOME COUNTRIES

4.1 Uganda: Integrating Mental Health into Public Health Care
The Hon. Captain M. G. Mukula, Minister of State for Health, Uganda

4.1.1 Health Situation Analysis

According to a 1995 Burden of Disease study in Uganda,[8] over 75 percent of life years lost from premature deaths are the result of preventable illnesses such as malaria, perinatal and maternal conditions, acute lower respiratory tract infections, HIV/AIDS and diarrhea. In addition to the heavy burden of infectious diseases, the country is simultaneously experiencing a surge in the occurrence of non-communicable diseases such as hypertension, diabetes, cancer, and mental and psychosocial disorders.

These statistics indicate that Uganda has entered the early phase of the epidemiological transition and must adjust its health care system accordingly. While infectious and other preventable diseases are considered Uganda's highest priority, selective attention has been given to all key determinants of health, including new health threats. Ugandan health has worsened with the advent of the HIV/AIDS pandemic and, due to the negative effects of prolonged armed conflict, vulnerable groups such as women and children have been disproportionately affected.

4.1.2 Health Policy Priorities

The Ugandan Government's focus has been providing health services that are proven cost-effective and have the largest impact on reducing morbidity and mortality. Moreover, highest priority has been given to the diseases that contribute the most to the disease burden. The cost-effective interventions chosen to address these priority health problems constitute the Uganda National Minimum Health Care Package.

The Government allocates the largest proportion of its health budget to funding the Minimum Health Care Package so that, in essence, health spending matches the magnitude of priorities reflected by the burden of disease. A key policy objective for the Government of Uganda has been to assure that the minimum package of public health and clinical services is provided to all its population, especially the poor, women and children. The package design is based on data regarding Uganda's national health profile and on affordable, realistic and cost-effective interventions.

4.1.3 Mental Health as a Key Component of the Minimum Health Care Package

To address the heavy and increasing burden of mental illness in Uganda, the Government decided to promote basic, district-level mental health programs and support them through referral services at the regional and national levels. This initiative is clearly outlined in Uganda's Mental Health Policy and Strategy.

4.1.4 Mental Health Policy and Strategy

The guiding principles for the mental health policy are clearly defined as:

❑ Integration of issues related to mental health and the prevention of substance abuse;

❑ Promotion of mental health and provision of health care in an integrated form, especially at the district level and especially targeting vulnerable and high risk groups;

❑ Prevention of substance abuse (alcohol and other psychoactive substances), especially among young people.

To ensure a comprehensive approach at all levels, a plan has been formulated to make sure district programs reach the communities.

4.1.5 Mental Health Activities

Central level: Activities are coordinated by the Principal Medical Officer, whose main role is:

❑ Ensuring the formation of policies and the review and evaluation of the mental health program;

❑ Developing mental health guidelines for the implementation of mental health services, including clear steps for the integration of mental health services into general health systems;

❑ Coordinating the development and distribution of national materials on mental health promotion and prevention;

❑ Developing and distributing guidelines for the introduction of mental health into paramedical, nursing, midwifery and medical school curricula;

❑ Coordinating central-level technical support supervision, monitoring, and evaluation of the implementation processes in an integrated manner.

Mental health has been effectively integrated into the top management committee in the Ministry of Health through a representative who is a senior consultant psychiatrist and serves as the Director of the National Referral and Teaching Mental Hospital.

Mental health professionals are trained through regular in-service programs run through the National Teaching Institution and co-developed by the Ministry of Health and the Psychiatry Departments of Ugandan Universities. Middle-level professionals are trained to oversee district-level mental health service administration, and the program ensures that there is a reasonable period of exposure to the district-level delivery of general health care services. In addition, national quality assurance teams possess diversified skills in order to ensure an integrated approach to the quality assurance support/ supervision strategy.

Regional level: Uganda's Health Policy calls for the provision of both integrated and specialized mental health service at this level. Though several regional mental health units were already in existence, over the last three years the Government has been able to operationalize its policy by

injecting state resources into mental health activities, and identifying a donor partner to help build necessary infrastructure and provide both human and logistic resources.

Teams of physicians and mid-level mental health workers, such as nurses, from the regional hospitals are required to travel regularly into their districts to offer technical support and ensure the implementation of national guidelines. Mental health education is also offered at this level through both vertical training and programs for continuing professional development.

District level: At this level, mental health services are fully integrated into the general health services. District health teams carry out integrated planning, procurement of drugs and other inputs, and supervision of lower-level health units within the communities. To ensure that policies are properly implemented, in-service training opportunities are offered locally and, when funds are available, national level programs held at the National Referral and Teaching hospitals are offered for district staffs' continuing professional development.

Lower level units: General health workers are regularly provided with basic training in mental health to equip them with the necessary operational skills to identify common mental health disorders. In this way, appropriate interventions can be initiated at the community level. The training also provides community health workers with the necessary skills to ensure timely mental health referrals to higher levels of care.

4.1.6 Financing the Mental Health Program in the Minimum Health Care Package

Health financing is largely supported by donor partners such as the World Bank, European Union and individual governments on a bilateral basis. Through a common basket arrangement, donor partners contribute approximately 50 percent of Uganda's entire health budget.

At the national level, the Government has substantially increased funding to the National Referral and Teaching hospitals involved in training human resources to support the mental health integration process.

4.1.7 Challenges

Despite the successes achieved over the last few years of Uganda's integrated Mental Health Program, there are still some challenges that must be addressed. These challenges include:

❑ Inadequate data on the national mental health disease burden;

❑ Inadequate human resources at all levels;

❑ Limited resources which affect health financing, especially the mental health division;

❑ Users and caregivers of mental health services are still faced with widespread stigma, a factor that limits the integration process.

4.2 Europe and Central Asia: Profile of Mental Health
Nedim Jaganjac, Consultant, Human Development Unit, ECA Region, World Bank

4.2.1 Mental Health Trends in Europe and Central Asia (ECA)

❑ *Significant component of the global disease burden:*

ECA countries face considerable challenges, particularly since the incidence of mental illness has not been matched with reforms in treatment and rehabilitation that have been developed in the West.

The overall burden of disease in the former socialist countries is estimated at 17.2% (DALYs), the second highest ranking after established market economies (25.1%) and notably higher than the world average (12.3%).

❑ *Adverse impact on economies and social structures*:

A major factor affecting the development of conflict/post-conflict societies and post-natural disaster societies is the mental health of their citizens. For the first time in 1990, the World Bank/WHO Global Burden of Disease study (GBD) identified the impact depression has in developing nations. In its original survey, the GBD found that depression was the fourth leading cause of disability as compared to all other health conditions, and predicted that in 2020, depression would be the second leading cause of disability in the world. In its research, however, the GBD focused primarily on non-traumatized developing nations. Recent large-scale epidemiological surveys have shown that in traumatized populations, depression can be up to seven-fold higher than baseline levels in non-traumatized societies, and post-traumatic stress disorder (PTSD) can be up to ten-fold higher. In addition, high rates of disability and premature death associated with chronic medical illnesses such as cardiovascular disease are associated with psychiatric morbidity in traumatized populations.

4.2.2 Treatments: Constraints and Possibilities

Macroeconomic crises have hindered efforts to develop alternative treatments. Many hospitals face severe budget constraints, and current national resources are insufficient to meet existing demands, let alone finance any community-based services. With respect to economics on the service level, poorly aligned financial incentives have led to a desire among some hospitals administrators to increase admissions. Not surprisingly, the lack of funding has led to poor quality care, low staff morale, and inadequate resources for even the most basic necessities.

As an example, until recently in Poland the allocation of funds among health care organizations was based on prior year budgets and involved no detailed analyses of costs. Under such schemes, there was little incentive to expand services and efforts to develop community psychiatric services were limited.

Most ECA countries now have one or more psychiatric association, and non-governmental health sector groups such as relatives' groups, psychiatric nurses' groups, and at least 100 mental health NGOs have emerged in the region.

4.2.3 Progress in Mental Health Policies

Assessment: The development of mental health reform strategies has been hampered by the lack of adequate epidemiological studies that assess true service "needs" based on actual levels of disease, severity, disability, and risk. As a result, governments may rely on service use or "supply" data as a proxy for actual health care needs, thereby making the need for reform less apparent. Lack of adequate economic evaluations of resource allocation formulas may hamper the cost-effective use of the few mental health resources that are available.

Policies: Few countries in the region have produced detailed mental health strategies as opposed to broad policies. For example, after years of pressure from the psychiatric association, the Bulgarian government approved a mental health policy document that includes priorities and time frames, but it specifies no mechanisms for moving from institutional to community care. Mental health policies often do not include strategies for developing social support (job opportunities, safety nets, etc). Community social structures, including the role of the family, were weakened first under the former, Soviet-style systems and later with the strain of economic transition. Struggling labor markets have meant limited attempts to develop employment opportunities for those with mental illnesses.

Legislation: Legislative reform of mental heath acts is underway in 13 countries in ECA. Service delivery systems are slowly developing away from custodial care institutions to alternatives such as community-based services. (The transition to community care is being implemented in Bosnia, Kosovo, Latvia, Lithuania, Poland, Czech and Slovak Republics and is at the development stages in Bulgaria, Turkey and Ukraine.) Having passed mental health legislation in 1995, the Lithuanian Government is now in the first stage of a ten-year program on mental disease prevention. Although a mental health policy and national program has just been developed in Turkey, there is not yet national legislation on mental illness. Finally, though the Estonian government does not yet have a formal mental health policy, it has passed legislation outlining both the rights of patients and criteria for involuntary treatment.

Community Care: The polyclinic system inherited from the former Soviet system does not yet provide a primary care system that is able to detect and treat people with common mental disorders. Community-based approaches to mental health are only beginning to be developed in a few ECA countries. Where they have been adopted they have resulted in a reduction in the number of beds at large psychiatric hospitals and have encouraged increases in the number of small psychiatric wards, day treatment hospitals, and mobile community teams. The transition to more community-based care is hampered by a lack of funding and complicated by Ministries of Health that see deinstitutionalization as a cost containment opportunity, rather than as a policy of transferring funds to community care.

Financing: The presence of health insurance schemes (either social insurance or private/voluntary insurance) may have little positive impact, as benefits are generally linked solely to biomedical health services. Community-based psychosocial services in Lithuania, for example, are excluded from health insurance coverage.

4.2.4 Challenges

Developing alternative means of treating people with mental disorders requires reform of traditional organizational structures and clinical practices. Given the prevalence of mental illnesses in ECA countries, as well as their social and economic impact, the need for significant reform is imperative. Fortunately, governments have begun to recognize the detrimental effects of mental disorders and have started to attack barriers to successful diagnosis, prevention, treatment and rehabilitation. Despite some progress, additional resources and continued momentum are necessary to ensure that initiatives do not suffer a disappointing fate.

4.3 Discussion

The session on Mental Health Programming for Low and Middle-income Countries finished with a discussion chaired by Florence Baingana, World Bank Senior Health Specialist for Mental Health. A participant from the American Red Cross pointed out that the terrorist attacks of September 11, 2001, have thrown a new light on the need for integrating mental health into public health care. Both the Hon. Captain Mukula and Nedim Jaganjac agreed that the terrorist attacks have brought public attention and awareness regarding the magnitude and impact of mental disorders. They asserted that it was crucial that the link between mental disorders and terrorism be further elaborated and examined.

A participant from a South African NGO asked for greater clarification on the percentage of the overall health care budget that was used for mental health in Uganda. Fredrick Kigozi, Medical Director of the Butabika Hospital in Uganda, answered that it was difficult to give an exact figure due to the integration of mental health into primary health care in Uganda. However, he estimated that 10 percent of the overall health budget was targeted for mental health.

Another participant stressed that in order to cope with mental disorders a change of structures was needed. Dr. Jaganjac noted that instead of adding new structures it would be more wise to use existing structures more efficiently.

One final point dealt with the need to expand the overall mental health focus since, in cases of conflict, health care personnel often work with minimal support while having to assume responsibility for a type and magnitude of emergency care for which they have not been trained and which could not have been foreseen. In such cases, a large number of the personnel themselves are traumatized by what they witness, the physical injuries they must manage, the long hours they have to work, and the fact that they often go unpaid and have little food security for themselves or their families.

5. ALCOHOL AND PUBLIC HEALTH

5.1 Alcohol in Development and in Health and Social Policy
David Jernigan, Center on Alcohol Marketing and Youth, Georgetown University

5.1.1 Alcohol-Related Problems

Alcohol-related health problems, including mental health problems, account for 4 percent of global years of life lost due to death and disability. They are the leading cause of death and disability in low-mortality developing countries, and the third leading cause in developed countries. Alcohol- related problems include:

Chronic disease:
- ❑ Conditions arising during the perinatal period: low birth weight;
- ❑ Cancer: lip, oropharyngeal, esophageal, liver, laryngeal, and female breast cancers;
- ❑ Neuropsychiatric diseases: alcohol use disorders, unipolar major depression, epilepsy;
- ❑ Diabetes;
- ❑ Cardiovascular diseases: hypertension, coronary heart disease, stroke;
- ❑ Gastrointestinal diseases: liver cirrhosis;

Injury:
- ❑ Unintentional injury: motor vehicle accidents, drownings, falls, poisonings, etc.;
- ❑ Intentional injury: self-inflicted injuries, homicide, etc.

Alcohol-related social problems are more difficult to measure, but include child abuse, domestic violence, school failures, negative impacts on family budgets, and greater utilization of social service resources by heavy alcohol users.

5.1.2 Relationship between Alcohol Consumption and Alcohol Problems

Alcohol problems arise from occasions of intoxication, repeated episodes of intoxication, and steady, heavy drinking. The bottom line is that the level of alcohol problems in a society will tend to rise with the level of alcohol consumption. Worldwide, alcohol consumption is falling in developed countries, remaining stable in Latin America and sub-Saharan Africa, and rising rapidly in Asia and Eastern Europe.

5.1.3 Social and Health Benefits of Drinking

Though alcohol tends to play a role as an integrative, bonding or socially lubricative substance, the social benefits of drinking are largely unquantifiable. As for health benefits, studies have shown that alcohol may have a protective effect against congenital heart disease, evident at the individual level at as low as one drink every other day. This benefit, however, has not been found at the aggregate level. One explanation for this difference is that some drinkers may shift to a more heart-healthy pattern as

others change to more dangerous patterns. In light of this information, there are no net benefits at the population level from any policy that seeks to increase alcohol consumption.

5.1.4 Alcohol and Development

Alcohol consumption tends to rise with economic development, absent mitigating factors (e.g. religion). With the trend increasingly towards industrial production of globalized beverages, consequences for development are mixed:

- *Employment and income generation:* Employment directly related to alcohol declines with industrialization. Conversely, indirect employment may increase in wholesaling and distribution, but is less likely to increase in retail sale.

- *Government revenue*: If the government controls the market, enhanced revenues can come through monopolies of production/sale or increased taxation. The latter can contribute to economic efficiency by correcting for negative externalities, to public health by reducing consumption, and to revenue raising, accounting for as much as 24% of national revenues.

- *Quality improvement*: Industrialization leads to greater uniformity and reliability of the product.

- *Sourcing of inputs and balance of payment issues*: Import substitution is constrained by the size of the domestic market and also may require the import of inputs as opposed to finished products. Alcohol production is also unlikely to make much contribution to exports.

- *Technology transfer*: Because "turnkey" technologies are increasing, and design, research and development, and engineering expertise remain in headquarters countries, little benefit accrues here.

- *Packaging and distribution networks:* Beer production in particular will encourage development of these.

- *Foreign direct investment:* Alcohol production can be an early form of this, but only if an increased alcohol supply will not worsen the public health and safety situation regarding alcohol.

5.1.5 Preventive Interventions

Research has generally found environmentally based interventions more effective than individual-based approaches.

Individual-based:

- *Education and persuasion*: There is little evidence of the effectiveness of school-based programs beyond the short-term. Media campaigns are unlikely to change behavior, but may increase support for more effective policies.

- *Deterrence*: Effective in reducing drinking and driving. The speed and certainty of punishment is crucial to its effectiveness.

❏ *Encouraging alternatives*: Little evidence of lasting effectiveness. Too many alternatives go well with alcohol, e.g. soft drinks, sports. Though programs which introduce alternate activities to drinking can improve the quality of life for disadvantaged populations by offering new opportunities, they seldom replace drinking.

❏ *Treatment and mutual help*: Part of a humane societal response. Brief interventions, and self-help are effective and result in net savings in social and health costs. Treatment alone is not a cost-effective means of reducing alcohol-related problems.

Environmentally based:

❏ *Reducing harm*: Server and manager training can reduce drinking and driving, and violence. The provision of public transport, and relocation of drinking places away from residences can also be effective. General protections such as airbags and sidewalks are effective. "Designated driver" programs lack evidence of effectiveness.

❏ *Regulating availability, conditions of use*:

  ▪ Prohibitions are difficult to enforce, but limited ones such as minimum-age drinking laws are effective if enforced.

  ▪ Taxation and other price increases are also effective if the market is under control, since demand for alcohol is generally inelastic.

  ▪ Research has also found that measures to make alcohol purchase less convenient, such as limiting sales outlets, hours and conditions of sale, can be effective.

  ▪ Government monopolies of retail sale can have substantial public health effects, while government production monopolies can assist in control of the market.

  ▪ Production restrictions can be effective but are difficult to enforce.

  ▪ There is some evidence that limits on advertising and promotion are effective, although "unmeasured" activities are increasing and difficult to regulate.

5.1.6 Policy Concerns

❏ Successful alcohol policies rely on social consensus, so participation of social and religious movements, civil society and NGOs can be of critical importance.

❏ Alcohol policy needs to be societal, integrated and consistent.

❏ International trade agreements need to recognize that alcohol is "no ordinary commodity" and make appropriate exceptions for it.

5.1.7 The Future

The alcohol-related burden is foreseen to increase in the future due to the following reasons:

- ❑ The disease categories related to alcohol are relatively increasing: chronic disease, accidents and injuries.

- ❑ Alcohol consumption is increasing in the most populous parts of the world.

- ❑ Patterns are stable if not getting worse.

Other Resources:

The World Bank's Public Health at a Glance fact sheet on alcohol may be found at: www.worldbank.org/phataglance

5.2 Alcohol and Drug Addiction Treatment in Russia
Dori Langevin, Project Director, Pacific Institute for Research and Evaluation

5.2.1 Project Background

This study describes the collaborative creation of a culturally relevant training model for alcohol and drug addiction treatment in Russia during 1995 and 1996. The study was funded by USAID and Dori Langevin served as the director of training in residence in Moscow.

Twenty-one Russian narcologists,[c] psychologists, family therapists, and recovery counselors comprised the Training of Trainers group (TofTs), which served as the primary resource for determining the "goodness of fit" of the American-born treatment model in the post-Soviet environment. The TofTs program was designed to help these professionals develop their teaching styles and encourage collaboration between Americans and Russians in preparing and implementing training for other Russian professionals.

Adapting the bio-psycho-social-spiritual (BPSS) model of treatment and recovery, the Russian-American team designed and delivered eight, 5-day Basic Training sessions and four, month-long Advanced Training sessions during the grant period. These were held across several regions of Russia and involved approximately 300 and 130 participants, respectively. Participants were mostly professionals (counselors, psychologists, narcologists, psychiatrists, family therapists), though some recovering alcoholics/ addicts or their family members also attended. It was hoped that participants would return to their settings equipped with the tools to implement the bio-psycho-social-spiritual model of treatment.

Completing the Basic Training was a prerequisite for participation in the Advanced Training. The goals of the Basic Training were to:

- ❑ Present the fundamentals of the bio-psycho-social-spiritual model;
- ❑ Present descriptions of treatment programs in Moscow that utilize the model;
- ❑ Assist trainees to explore their attitudes toward alcoholism, drug addiction, and codependency;
- ❑ Create a Culture of Recovery in which every interaction became potentially useful to the education and personal change processes;
- ❑ Provide the opportunity for trainees to experience their own growth in small groups;
- ❑ Prepare trainees to attend Advanced Trainings;
- ❑ Instill hope for recovery and encourage involvement in local, 12-step meetings.

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[c] Physicians who specialize in addiction treatment

The goals of the Advanced Trainings were to:

❑ Teach fundamentals of group process, family counseling, and individual counseling;

❑ Teach fundamentals of addiction treatment through lecture-discussions and fishbowl demonstrations of the assessment interview, individual therapy, and group process; (TofTs solicited volunteer clients from aftercare programs and private practice settings. Most volunteers were involved in multiple group demonstrations.)

❑ Define the need for a multidisciplinary team including the roles of the physician (narcologist), chemical dependency therapist (monitor), family therapist, recovering counselor (consultant), clinical supervisor, and program director;

❑ Teach the treatment planning process and treatment documentation;

❑ Deepen the clinical understanding of a Culture of Recovery by bringing attention to the parallels between in-class interpersonal interactions and therapeutic relationships in treatment;

❑ Deepen trainees' clinical capacities through their own growth and understanding of group process, facilitated by their participation in daily small groups.

TofTs met weekly, participated in two sets of group interviews exploring the cultural relevance of the BPSS model for Russia, and underwent individual exit interviews assessing changes in their personal experiences during the 16-month study. Other sources of data included dialogue with the Basic and Advanced Training participants, communications with the patients and staff of the Recovery Treatment Center in Moscow, and Dori Langevin's parallel experience as a "foreign transplant" working in Russia. The data consistently resonated with the humanistic BPSS approach.

The Russian voice in the project comes out through extensive interview excerpts describing recoveries from alcoholism, drug addiction, and codependency in the four thematic areas of epiphanies, spirituality, narcology, and authority. The personal and professional stories document the revolutionary introduction and development of the Russian 12-Step recovery-based treatment, first initiated in Kiev in 1985 and currently performed by a treatment unit in Moscow. The study team looked closely at how the American-born bio-psycho-social-spiritual model must be modified to complement the existing Russian model.

The transfer of authority from Americans to Russians was central to sustainability of the training. The interplay between authority, control, and codependency are related to current and historical features of Russian culture. Special attention was also paid to the relationships that developed between Russians and Americans, and how the encounter changed those involved as they practiced parity of power and healed misconceptions from the Cold War. According to Dr. Langevin, cultural relevance resulted from practicing cultural sensitivity, which flourished, not as a result of any specific field of knowledge, but through an openness of heart and mind.

In November 2000, Dr. Langevin returned to Moscow to visit the TofTs and eight of their treatment centers, which further illuminated the cultural, social, and political factors that contributed to the bio-

psycho-social-spiritual model's excellent goodness of fit in Russia. According to Langevin, since Perestroika, Russia has begun the shift from a Culture of Addiction to a Culture of Recovery.

In addition to the entrepreneurial expansion of private treatment services, the most outstanding change Dr. Langevin witnessed was the dramatic increase in young (18-24 years old) heroin addicts in treatment. They comprised 75-90 percent of the clientele in seven of the eight treatment centers she visited during her return trip.

5.2.2 Guidelines for Introducing Alcohol and Drug Treatment Programs to other Cultures

Those guidelines that were useful during the grant and study period included:

1. Being familiar with cultural, historical, political, and sociological factors that contribute to customs, norms, settings and myths about alcohol/drug use, abuse and addiction;

2. Being familiar with current methods of treatment and understanding them in the context of cultural, medical, and spiritual values;

3. Understanding attitudes towards alcohol/drug abuse and addiction and recovery within the treatment settings and among treatment providers;

4. Finding allies willing to break out of the cultural constraints that sustain stigma regarding addiction and recovery;

5. Understanding our own motivation and intention in bringing methods that are effective in America to other countries, and the necessity of co-creating culturally relevant alternatives;

6. Being humble as often as possible, being willing to be changed by the experience, and seeing ourselves in the roles of student as well as teacher.

6. MENTAL HEALTH AND EARLY CHILD DEVELOPMENT (ECD)

6.1 School-wide Positive Behavior Support
Renee Bradley, US Department of Education, Special Education Programs

School-wide positive behavior support (PBS) consists of a broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior. The work began as a direct response to the dilemma that children with the most challenging behaviors often are not able to participate in public school settings, but are asked to leave or put in alternative sites. The program initially tried to go into schools with interventions and practices aimed specifically at children with severe behavior problems. What was found, however, was that schools had so many other issues to address that they had nothing else to offer challenged children. The project implementers soon realized that in order to serve the high need group, they had to establish a foundation which first served all students well, then addressed the needs of a second level needing slightly more help, and finally met the demands of the high-need third level. Studies have shown that approximately 80 percent of students belong to the first group, 15 percent are in group two and need some remediation, and 5 percent make up group three, needing highly individualized, intensive services.

When looking at disability categories, emotional disability encompasses the group of children with behavior problems. Though behavior problems can be extrinsic or intrinsic, teachers are more likely to focus on the often disruptive extrinsic children, and often end up overlooking the students who are severely depressed, self-mutilate, etc. In 1975, when the first disability law was passed relating to schools, experts thought that approximately 2 percent of the school-age population would be categorized as having disabilities. However, the most conservative mental health estimates show that at least 3 percent have some form of disability, and more liberal estimates claim the figure is closer to 33-36 percent. Despite these statistics, almost never are more than one percent of students receiving treatment in schools for disabilities.

The School-wide PBS model leads to socially important outcomes such as academic gains and improved social competence, and helps create an environment in which students feel safe. The model carefully considers how to train staff in how to deal with children with behavior problems, provides support to students and makes decisions based on empirical data. The model seeks to invest in all students before problems develop and advocates for comprehensive support for children through a variety of channels (i.e. community, family, etc.).

6.1.1 Model Outcomes

A study of 76 Illinois elementary schools showed that, on average, the 31 that took part in the program had substantially fewer office discipline referrals than the 38 schools that were not in the program. Likewise, the model is associated with a decrease in student "risk factors" such as anti-social behavior, crime, and drug and alcohol use, and an improvement in "protective factors", academic performance, and social competence. The decrease in office discipline referrals, furthermore, has been shown to lead to substantial savings in administrator and student time that can be used much more productively. Teachers, for example, will have more time to spend with high need students.

6.1.2 Summary of Research Results

Investing in School-wide Positive Behavior Support results in:

- Change in school discipline systems

- Reduction in problem behavior: detentions, suspensions, expulsions, etc.

- Improved academic performance: increased standardized test scores

- Saving in staff and student time

- Improved effectiveness of individual interventions

- Improved perception of school safety, mental health

Other Resources:

For more information about the School-wide Positive Behavior Support program, please visit www.PBIS.org.

6.2 Twitezimbere: NGO from Burundi
Pontien Bikebako, Director Twitezimbere, Burundi

6.2.1 The Current Situation

Poverty in Burundi has increased significantly since the 1993 outbreak of internal conflict. In 2000, 67 percent of the population was deemed poor. Furthermore, despite modest improvements, the gross primary school enrollment rate has remained below its pre-crisis level, at 63 percent. In addition, formal pre-schools cover only 1 percent of all children, at best. The Education Policy adopted in 2002 explicitly recognizes the benefits of pre-school education and a bill to increase pre-school teaching within the country is currently being prepared.

6.2.2 Early Child Development Program (ECD)

The ECD Program is part of the World Bank sponsored Social Fund Project. It relies on an integrated approach, combining health, nutrition and psychosocial support for young children. The project began its activities in 2000, in four pilot communities in the north of Burundi. Today, the program covers 19,000 households in 34 communities. Direct and indirect beneficiaries include as many as 600,000 children.

The local NGO Twitezimbere is entirely responsible for the program's implementation. As a facilitator agent, Twitezimbere helps local communities mobilize themselves, and sensitizes them on various issues related to children's needs. Through a participatory diagnosis, Twitezimbere helps communities identify their needs, establish development priorities, and determine ways to set and achieve their goals. Local mothers committees are elected to conduct many of the interventions.

With Twitezimbere's support, mothers committees identify actions they deem important, such as information, education and communication (IEC) activities or anti-malaria and parasite campaigns. Mothers committees in selected communities receive training on: (1) childhood disease identification, prevention and care; (2) ways to improve household nutritional potential; (3) child cognitive development: and (4) project content and the role of the community in activity selection and implementation.

A team specializing in public health, nutrition and pediatrics performs the trainings, and pre-school staff are specially trained by psychotherapists. Furthermore, pre-school staff members are chosen by the communities themselves based on criteria such as morality, credibility and educational attainment levels.[d] All trainers are sub-contracted by Twitezimbere, with the overall goal being for the trainees to eventually train their peers.

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[d] Pre-school staff generally are required to have completed primary school.

6.2.3 Expected Outcomes

❑ *Increased community participation:*

- Improved community mobilization in decision making, basic service delivery and monitoring;

- Increased number of people trained on ECD issues;

- Improved social stability through job creation and increased cooperation among community members;

- Better understanding and knowledge of good health and nutrition practices for children, and on their psychosocial development.

❑ *Improved child health and nutrition*

- Reduced child morbidity and mortality;

- Improved access for children to nutritious food;

- Reduced frequencies of micro-nutrient deficiencies;

- Improved mother and child nutritional status.

❑ *Improved child psychosocial development and learning processes*

- Improved community capacities to foster the psychological development of children;

- Improved living conditions for orphans and refugee children;

- Increased protection against poverty for children and their mothers through the development of ECD via IEC activities.

6.3 Discussion

During the discussion, one seminar participant addressed the problem of obtaining accurate epidemiological data for children's mental and neurological disorders, especially for the developing world. The participants acknowledged the need for generating and compiling mental health information through analytical work.

Another participant stressed the importance of effective coordination between governments, NGOs and the private sector. It was agreed that such coordination is vital to the success of mental health and psychosocial programming, for improved access and affordability. The majority of psychosocial programs in developing countries are currently provided by NGOs.

7. ROUNDTABLE DISCUSSION

Judy Heumann, the Disability Advisor at the World Bank, facilitated a roundtable discussion with panelists from the Bank's partner organizations.

One of the issues that arose during the roundtable discussion was the problem of limited monitoring and evaluation for mental health activities. Improved monitoring and evaluation of current programs would provide process, outcome and impact indicators that could aid in the replication of programs and facilitate larger-scale applications. Thus far little has been done to determine such indicators for developing countries. Since the causes of mental disorders are multifactorial, the interventions must be multisectoral and indicator development will be complex.

Several participants described the Bank's positive influence in developing countries, specifically the Bank's direct link to Ministries of Finance, as a useful comparative advantage.

The challenge of mainstreaming mental health into relevant Bank instruments was also discussed during the roundtable. Although many countries around the world do have mental health programs, we are only now documenting the reasons for the successes and failures of these programs. This documentation must be evaluated and the outcomes disseminated. Developing a toolkit for dealing with global mental health issues is a challenge for the Bank since evidence is so scarce.

The discussion concluded with the point that, although current experiences in mental health provide some guidance on the dimensions that must be addressed, more research and development of good practices is clearly needed. Given the Bank's experience in the area of knowledge generation and dissemination, a vital role for the Bank within the field of international mental health is in research and development.

8. MENTAL HEALTH AND CONFLICTS

8.1 Harvard Program in Refugee Trauma
Richard F. Mollica, Director of the Harvard Program in Refugee Trauma

8.1.1 The World Bank-Harvard Program in Refugee Trauma

In Bosnia, half of the population was displaced and 200,000 people died as a result of the 1992-1998 conflict. According to official statistics, between 1991 and 2000 the population declined from 4,395,643 to 3,683,665, and monthly income plummeted from a per capita level of $299 to $174. Two years after the conflict officially ended, there were still 643,250 refugees and 501,000 displaced people, and the ratio of employed to unemployed was equal to one.

The World Bank Post-Conflict Unit supplied funding to the Harvard Program in Refugee Trauma (HPRT) to pilot a culturally appropriate mental health program within the primary health care system of one canton in Bosnia and Herzegovina (BiH). The three-year program, which ended in March of 2003, was carried out in the Travnik Canton. Its focus was on training primary health care providers to handle mental health issues, since widespread trauma and limited resources make community-based mental health interventions key in post-conflict societies. The project's major objectives were to:

❑ Provide training and technical assistance to primary care providers (PCPs) so they can identify and treat psychiatric disorders and physical disabilities resulting from the recent war trauma;

❑ Create a network of PCPs skilled in mental health care and supporting each other in the treatment of persons with trauma-related and other mental health disorders;

❑ Develop with the cantonal Ministry of Health an approach to the provision of mental health services integrated into all levels of the primary health care system, including community based rehabilitation services (CBRS);

❑ Produce sustainable results by integrating this project into the BiH health care reform, including BiH's continuing medical education activities;

❑ Evaluate the achievement of objectives so that lessons learned can be disseminated to other cantons and other countries in the region.

8.1.2 Conflict, Mental Health and Physical Health

To better understand the scope of mental health issues in the Travnik Canton, the HPRT conducted one of the first longitudinal studies of refugees which addressed mental health outcomes, including mental health functioning over time. The baseline survey took place in 1996 as refugees poured out of Bosnia and into Croatia, and was administered again in 1999 after many of the refugees had returned home. At baseline, approximately 55 percent of the population was asymptomatic, while the remaining 45 percent suffered from PTSD (5%), depression (20%), or a combination of both (20%). The study found that, among the a-symptomatic population, there were very few problems in physical functioning. However, around 40 percent of refugees with depression, and 45 percent of refugees with combined depression and PTSD, had physical conditions that "were found to be unremitting, disabling, and

associated with premature death."[9] Furthermore, higher rates of psychiatric stress were associated with higher and higher rates of problems in physical functioning. Though there is a general idea that, after an outpouring of nightmares and grief, 80 percent of the population recovers from the conflict experience, the data collected by the HPRT shows that this assumption is incorrect for refugees.

We are beginning to see that the health effects of chronic depression over time are quite strong. More and more literature shows that chronic depression, even depression below the level for diagnosis, has an enormous impact on cardiovascular disease, stroke, and hypertension, and may also be related to cancer. As a result, we are looking at the economic impact of increased mortality and morbidity, and must therefore look at the whole picture of health and mental health.

8.1.3 Training

With the support of Bosnian medical professionals, HPRT developed a curriculum and approach for training 105 primary care practitioners (PCPs) in the canton. The curriculum included training in psychosocial interviewing skills, screening instruments, identification and management of the most common psychiatric disorders, identification and management of disability, and management and health reform skills. Continued on-site supervision was a critical part of the program sustainability, so that the new skills and capacity were maintained. The level of trauma experienced by the PCPs was also taken into account in planning and implementing the training.

8.1.4 Policy Options

An interesting relationship exists between the economic background of chronically depressed people and the role it plays in promoting resiliency and protection against depression. According to Mollica, the best anti-depressant is a job. He asserts that the immediate post-conflict phase is the ideal time for the World Bank to make a contribution to the reconstruction process by creating opportunities for employment. The Bank is in a strong position to make the point that people who have been through mass violence and conflict need to work. Moreover, they can't wait five years for the factories to be built, since by then dependency has set in and irreversible economic, physical, and mental damage has been done.

For the last twenty years, if mental health was addressed at all in post-conflict situations, policy focused solely on serious mental illness. Because serious mental illness affects a relatively small number of people, it was generally not considered a priority. Meanwhile, mental health problems among the general population were largely ignored (i.e. physical incapacitation, serious family conflict, clinical depression/PTSD, fear of government, justice/ revenge seeking behavior, physical and mental exhaustion, and demoralization). When you begin to see the impact of mental health problems on social capital, however, you can begin to understand the importance of addressing them.

In September of 2002, the BiH Ministry of Health hosted a meeting in Sarajevo of ministers from seven, post-conflict countries. The ministers were asked to use their combined experiences to create a framework for mental health recovery in post-conflict societies. Their suggestions included:

1. Determining the role of mental health **policy and legislation,** establishing community based rehabilitation facilities, and including mental health data from household surveys within national health statistics to improve the accuracy of national data;

2. Setting up a system for the sustainable **financing** of mental health within primary health care and developing cost-effective mental health training programs and services;

3. Establishing **science-based mental health services** that acknowledge the local culture and take traditional practices into account;

4. Incorporating mental health into **multi-disciplinary education** in medical schools and continuing education programs for medical professionals;

5. Coordinating the **role of international agencies**, local ministries of health and NGOs in order increase the effectiveness of mental health initiatives, and supporting the right of ministries of health to take the lead in the collaboration process;

6. Understanding the **link between economic development and human rights,** which are often violated in conflict situations. Both patients and providers are exposed to violence during conflicts, and violence-induced trauma has a negative impact on mental health. Poor mental health negatively impacts social capital and physical functioning and undiagnosed and untreated mental health problems place a significant burden on the health care system.

Figure 1: Framework for Mental Health Recovery
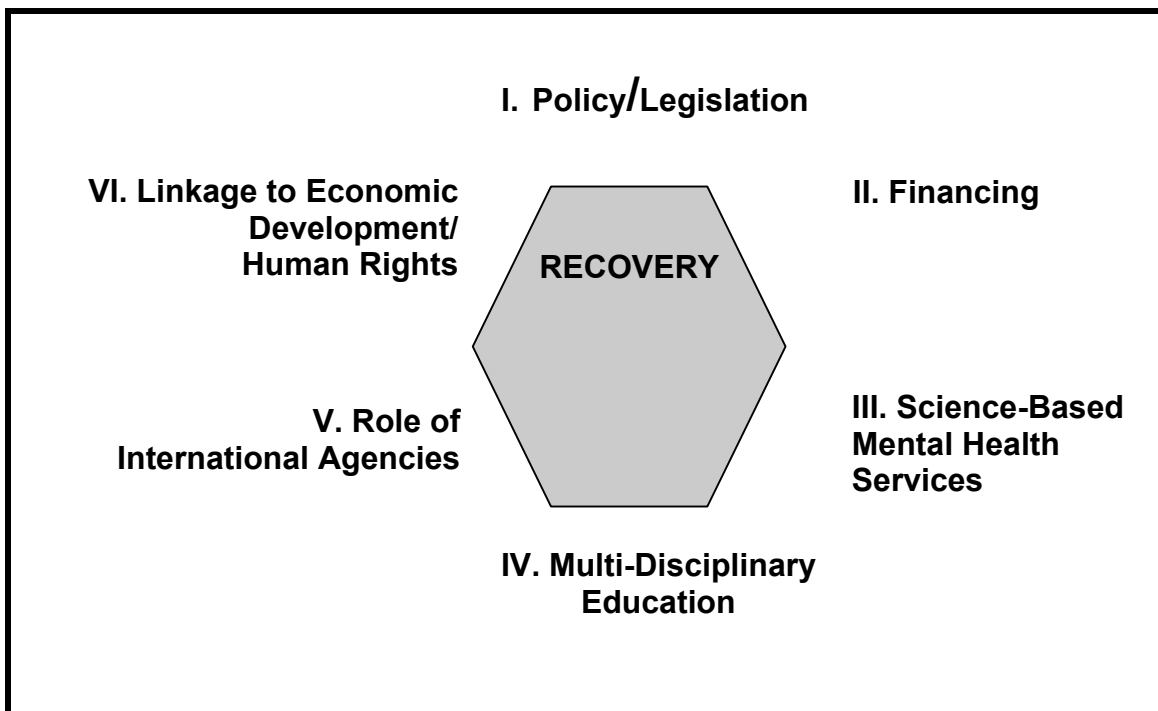
By discussing their own experiences and developing the Mental Health Recovery Framework, the participants hoped to help other post-conflict nations address the mental health needs of their populations.

8.2 Mental Health in Bosnia Herzegovina
Jovic Stevan, Assistant Minister, Ministry of Health and Social Welfare,
Republika Sprska, Bosnia Herzegovina

8.2.1 Health Situation Analysis

The war in the former Yugoslavia was one of the bloodiest and most intense in recent times. Although its adverse effects spanned the entire region, Bosnia Herzegovina was the most badly and intentionally damaged area. The war gave rise to the term "ethnic cleansing".

During the course of the four-year war almost 200,000 persons were killed and at least 180,000 were wounded, many of them gravely, with severe long-lasting repercussions. In addition to the massive physical trauma that occurred, the nature of the war was such that it caused even greater psychological damage to the population.

Besides causing massive physical and psychological morbidity, the war effectively destroyed human and material components of the health care system. Health facilities, including hospitals, had been damaged to such an extent that they could no longer function. In addition, much of the equipment in health facilities was either damaged or could not be maintained.

8.2.2 Main Objectives of Health Policy in Republika Sprska (RS)

The health policy in RS centers around four main objectives that compose its foundation. These objectives are: (1) equity in health status of all social groups, (2) health status improvement and improvement of equity in access to health protection (with emphasis on vulnerable groups), (3) reorientation of the organization of health care toward prevention and improvement of overall health protection, and (4) improvement in efficiency and of quality of health care.

In carrying out these objectives, in 2002 the Parliament and Government adopted a strategic regulatory framework, mainly composed of the *Health Care Policy and Health Care Strategy until 2010,* and the *Strategic Plan for Health Care Reform and Reconstruction*. One aim of these initiatives is that the psychosocial status of the population will improve and comprehensive and efficient services will be available to mental health patients by 2010.

8.2.3 Health Policy Strengths and Weaknesses

The strengths of the health policy in Republika Sprska exist in the support of the central government, strong user associations, international bodies, progressive legislation, and experience. The latter comes from seven years of reform towards community-based models. The weaknesses are poor intersectoral collaboration, insufficient allocation of resources, lack of support at the local level, and a resistance to change.

8.2.4 Health Policy Opportunities and Threats

On the one hand, health policy faces great opportunities such as the mobilization of the media and additional legislation in the area of mental health. On the other hand, however, dangerous threats to health policy are a possibility in the future due to the long process of reform and the possibility of losing focus, fund reduction, political instability and priority shifts.

8.3 Discussion

The discussion was chaired by Ian Bannon, Manager of the Conflict Prevention and Reconstruction Team of the World Bank.

One participant cited the link between mental health rehabilitation and job creation as a role for the World Bank to facilitate. Another participant raised the issue of the need for collaboration within and between sectors, both vertically and horizontally. In order to have an effective mental health program there must be horizontal collaboration within the health sector itself, i.e. between public health, mental health, reproductive health, children's health, HIV/AIDS, the Essential Drug Program, the Quality Assurance Units, and others. Vertical coordination is also critical for effective referral systems from the primary care level to tertiary hospital services. Finally, the collaboration needs to extend outside the health sector to other areas of government such as social protection and education.

Dr. Bannon concluded the discussion, emphasizing the importance of enhancing the economic arguments related to mental health interventions. Given the Bank's expertise in economics, Bannon found this to be a natural role. It is also critical that the most cost-effective mental health and psychosocial interventions be clearly determined. Although work is now well underway to identify the costs and effectiveness of such interventions in developing countries, a major product from this work needs to be a costed, essential mental health care component of a health sector package, social protection program or educational sector package. Clear measures of the incremental cost and incremental returns on these investments are critical.

9. THE WAY FORWARD

9.1 Outcome of the Seminar

During the final discussion facilitated by Jacques Baudouy, Jean Jacques Frere, of MENA, and Katja Janovsky, WHO Representative at the Bank and IMF, made brief presentations.

Jean Jacques Frere emphasized that the lack of data and the absent agenda for mental health comprised the two most significant challenges facing mental health interventions. Katja Janovsky found the division of labor between the WHO and the Bank to be clear: the WHO should provide technical advice and the Bank, economic analyses. According to Dr. Janovsky, such a division would lead to a fruitful and complementary partnership.

Florence Baingana, World Bank Mental Health Specialist, then summed up the key issues highlighted over the course of the seminar. According to Dr. Baingana's summary, the Bank should engage more strongly in the area of mental health for the following reasons:

1. The World Bank has convening power.

2. The World Bank has a direct link to the Ministries of Finance in client countries and they are often the decision making entities when it comes to the financing of national programs.

3. The World Bank has the ability to work easily across sectors without having to move across institutions, such as with education, social welfare, agriculture, health, and legal and judiciary reform.

4. The World Bank can link into PRSPs CASs, PERs and would thus link directly into client country planning and financing of development programs.

5. The World Bank has strength in costing, financing, and sectoral reforms.

6. The World Bank has a proven track record.

7. The World Bank is the lead funding agency for the social sectors.

8. The World Bank is strong in the area of knowledge generation and dissemination.

9. The World Bank has potential for exponentially increasing analytic work if it is linked into LSMS, CAS, PER, DHS, HHS, CWIQ etc.

10. The World Bank has the ability to put government at the centre of countries' mental health programming.

11. The World Bank has the ability to link mental health rehabilitation with job creation.

Florence Baingana concluded the summary, asserting that the World Bank, as was shown above, does have a comparative advantage in the area of mental health.

9.2 Discussion

The discussion that followed this closing session centred on the future role for the World Bank in the mental health arena. A number of participants emphasized the Bank's potential for generating data and providing cost-effectiveness studies.

Jacques Baudouy agreed with this consensus, especially with the idea of the Bank's comparative advantage in the economics of mental health, development and mental health, and in the links between poverty, loss of productivity and mental health. Dr. Baudouy contended that one reason the development agenda is not going as well as anticipated may be because mental health and its negative impacts have been largely ignored.

As the discussion progressed, participants addressed the current knowledge gaps, lack of sufficient data, and need for more monitoring and evaluation for mental health. Having already established that the Bank has a comparative advantage in mental health, the participants now turned to how this advantage could be best transferred into concrete actions. The participants also acknowledged that, in order for the Bank to address mental health, it must be specifically on the international agenda.

One issue that was not mentioned directly is that of human rights. People with mental disorders are often voiceless and excluded. Though it would not be directly involved in human rights advocacy, the Bank is in a position in which it could play a substantial role in getting mental health onto the Human Rights Agenda. It is critical that these issues be addressed at regional WHO meetings so that key concerns regarding mental health are raised by critical players from the client countries themselves and, thus, are brought into the global consciousness. The issue of mental health's inclusion has to be approached strategically, such as through concretely outlining the substantial costs of not intervening.

In closing, Dr. Baudouy thanked all of the participants and the various speakers. He stated that an expert team had been brought together and that the work accomplished at the seminar would be invaluable in aiding the Health, Nutrition and Population Unit and the Bank as a whole in determining the way forward for mental health initiatives.

SECTION TWO

WORLD BANK APPROACHES TO MENTAL HEALTH THEMES

1. WORLD BANK APPROACHES TO MENTAL HEALTH THEMES: An Overview

The second half of this document explores specific thematic areas related to mental health that must be addressed, and discusses how the Bank's future work can build on what it and its partner organizations have already accomplished in these areas. The themes that are dealt with in this second section are: conflict and post-conflict, early child development, mental health in primary health care, orphans and vulnerable children, HIV/AIDS, and violence against women.

Because mental health is influenced by a wide array of factors, mental health interventions must be multi-sectoral in scope. A holistic approach to mental health means not only including mental health components in all aspects of health care, but in the legal and judiciary sector, within education, and throughout conflict and emergency responses, among other areas. Failure to include mental health considerations in these sectors is not only a lost opportunity, but an economic and humanitarian risk to societies as a whole.

In 1994, a World Bank Early Child Development project in Argentina included the Bank's first "mental health and social development" component. Since then, mental health considerations have been supported in World Bank projects and partnerships in a variety of sectors through operational activities, analytic work, and knowledge management as illustrated below.

OPPERATIONAL ACTIVITES

Legal and Judiciary

- ❑ Providing technical support in mental health as part of a Legal and Judiciary Reform project in **Sierra Leone**. The project included assessing the feasibility of integrating mental health components in Legal Aid Clinics and within Peace and Reconstruction activities.

Health and Health Sector Reform

- ❑ The first stage in de-institutionalization of people with mental illness in **Albania, Lithuania and Romania** under Health Sector Reform Projects;

- ❑ Assisting countries such as **Lithuania, Zambia and Trinidad Tobago** to reform mental health services using the Mental Health Policy and Services Template which was developed by an internal team, led by the Bank's mental health specialists;

- ❑ Support to the Ministry of Health in **Thailand** for mental health reform;

- ❑ Technical support in mental health to the **Afghanistan** Health Project;

- ❑ Technical support to **Lesotho** in mental health policy development, community health assessment and mental health's inclusion in the District Health Package.

Early Child Development

❑ Psycho-social component of ECD within a Social Action Project in **Burundi**.

Conflict and Emergencies

❑ The integration of mental health into primary health care in **Bosnia**, funded by the Post Conflict Unit of the World Bank, by training primary health care physicians in the management of common mental disorders;

❑ The integration of mental health into primary health care in the **West Bank and Gaza** by streamlining referral mechanisms, addressing children's mental health needs, and developing an in-patient care master plan and mental health information system;

❑ Technical support to **Turkey** in the development and implementation of an emergency mental health response to earthquakes, within the framework of a new national mental health policy.

ANALYTIC WORK

❑ In **Bosnia**, the Harvard Trauma Questionnaire and Beck Depression Inventory were integrated as a module in the Living Standards Measurement Survey (LSMS). The data were collected in 2002 and preliminary analysis indicated a very high rate of depression. A validation of the questionnaire was then carried out and the results are to be released as a discussion paper in fiscal year 2005 by the Development Economics Group of the World Bank.

❑ In **Burundi**, the Statistical Institute and Economic Surveys of Burundi included 12 mental health questions on the 1998 national Burundi Priority Survey, which were adapted from the General Health Questionnaire (GHQ-12), used worldwide to gauge mental distress. In 2002 the Core Welfare Indicators Survey was conducted, again including the GHQ-12, as well as the AUDIT (Alcohol Use Disorders Test). The data have been collected and are being prepared by the World Bank for analysis.

KNOWLEDGE MANAGEMENT

An array of seminars and papers dealing with mental health have been prepared by World Bank staff and external partners, and include:

Seminars

❑ Mental Health and the Global Development Agenda: What Role for the World Bank? Washington, DC: 24-25 November, 2003.

Publications

❑ Baingana, Florence and Ian Bannon. "Mental Health and Conflict." *Social Development Notes: Conflict Prevention and Reconstruction*, no. 13, ed. Sigrun Aasland, Washington: World Bank, October 2003.

❑ Beeharry, Girindre, Harvey Whiteford, David Chambers, and Florence Baingana, "Outlining the Scope for Public Sector Involvement in Mental Health," HNP Discussion Paper, Washington: World Bank, August 2002.

❑ Cullen, Michelle and Harvey Whiteford. "The Interrelations of Social Capital with Health and Mental Health." Commonwealth of Australia, June 2001.

❑ Mental Health at a glance Fact Sheet, latest revision October 2003 www.worldbank.org/phataglance

❑ Yule, William, Rune Stuvland, Florence Baingana, and Patrick Smith. "Children in Armed Conflict." In *Trauma Interventions in War and Peace: Prevention, Practice and Policy*, edited by Bonnie L. Green et al., 217-242. New York: Kluwer Academic/ Plenum Publishers, 2003.

The remainder of this document is dedicated to exploring past and present World Bank mental health interventions in diverse sectors, in the theme areas conflict and post-conflict, early child development, mental health in primary health care (PHC), orphans and vulnerable children, HIV/AIDS, and violence against women.

Each section will begin by exploring the theoretical relationship between the given theme and mental health. A discussion of World Bank projects dealing with mental health in each topic area will follow to illustrate the Bank's mental health interventions in countries with varied political, social, historical and economic backgrounds, and to highlight areas for future mental health interventions.

2. CONFLICT AND POST-CONFLICT

2.1 Theoretical Basis: The Link between Conflict and Mental Health

Under normal circumstances, 1-3 percent of the population have some form of psychiatric disorder.[10] In conflict situations their prevalence is increased. Violent acts such as targeted killings, amputations, rape, and physical maiming often have long-term psychological effects on those who have experienced or witnessed them. Other forms of conflict-related violence can include forced displacement, restricted movement, limits on self-governance, and obstacles to establishing or continuing educational programs. Violence, furthermore, leads to displaced populations, a lack of basic services such as healthcare, education, water and sanitation, and widespread insecurity.

Mental disorders and psycho-social consequences associated with conflicts include sleeplessness, fear, anger, aggressiveness, depression, flashbacks, alcohol abuse, suicide, and domestic and sexual violence. Following a traumatic event, a large portion of the population may experience nightmares, anxiety, and other stress-related symptoms, though these effects are often short-lived and tend to decrease in intensity and rate of occurrence over time. Failure to address mental health and psycho-social disorders in conflict-affected populations will hinder attempts to increase social capital, promote human development and reduce poverty.[11] A summary of studies analyzing the psychosocial and mental health consequences of conflict are presented in Table 1.

Table 1:
Summary of Studies conducted on psycho-social /mental health consequences of conflict.

Country	Study Population	% Affected	Author/s and Year
Thai Cambodian Border	993 Cambodian refugees	15% PTSD 55% Depression	Mollica et al., 1993
Gaza Strip	550 torture survivors	20% PTSD	El Sarraj et al., 1996
Algeria, Cambodia, Ethiopia and Gaza	3,047 refugees, internally displaced persons (IDPs), and post conflict survivors	**Psychopathology:** 17% among non-traumatized vs. 44% of those who experienced violence **Lifetime prevalence:** 29% PTSD 12% Depression 25% Anxiety Disorder 5% Somatoform Disorder	De Jong et al., 2001 Submitted for publishing
Uganda	IDPs 55 experienced trauma 58 did not experience trauma	**Trauma Group:** 53% PTSD 62% General Anxiety Disorder 71% Major Depressive Disorder **Non-trauma Group:** 5% Anxiety Disorder No Depression or PTSD	Muller et al., 2002

Uganda	49 Sudanese Refugees	25% PTSD 58% Major Depression	Sieswerda et al., 2002

Source: *Trauma, War and Violence. Public Mental Health in a Socio-Cultural Context*, edited by Joop de Jong, 2002.

2.2 Case Study I: The West Bank and Gaza

General Statistics[12]

Population:	3.2 million
Population growth:	4.3 %
Life expectancy:	72.7 years
GNI per capita:	1,110 US$
GDP:	4.4 billion US$
Infant Mortality Rate:	23
Crude Death Rate:	4

2.2.1 Historical Background[13]

The UN General Assembly's 1947 resolution recommending that the British Mandate of Palestine be divided into a Jewish state and an Arab state ignited a conflict that has plagued the region ever since. War erupted between Arab and Israeli forces in 1948 and, before the year ended, between 600,000 and 760,000 people had fled from Israel and the disputed territory had been parcelled out between Israel, Egypt and Jordan. At the time, the Jordan River's West Bank and the Mediterranean Coast's Gaza Strip were the only two pieces of what was once Palestine, left under Arab jurisdiction.

The conflict was rekindled between Israel and the combined forces of Egypt, Syria and Jordan in 1967, resulting in Israel's occupation of East Jerusalem, the West Bank, the Gaza Strip, the Golan Heights and the Sinai Peninsula (since returned to Egypt). The war and forced evictions that followed triggered the migration of several thousand Palestinians from the region. Between 1987 and 1993 the Palestinians retaliated against Israeli occupation through the first organized *Intifada*, or uprising, which has since included a chain of suicide bombings targeting Israeli soldiers and civilians. Israel has met these actions with tightened security, arrests, school and university closings, increased land confiscation, and property demolition. In 2002, Israel began the construction of a 400-mile security barrier to divide the West Bank from Israel, a measure which has further fueled the conflict.

Though there have been several attempts to bring peace to the region, a permanent agreement has yet to be reached. The process of reconciliation began in 1991 in Madrid with the signing of the Israeli-Palestinian Declaration of Principles. This step was followed by a series of agreements transferring some control over the areas of West Bank and Gaza to the Palestinian Authority. However, neither these measures nor the mediated talks held at Camp David in 2000 resolved the overarching issues of control of Jerusalem, the fate of Jewish settlements in Gaza and the West Bank, and Palestinian refugee

status. In 2000, hostilities again flared in the region, Israeli-Palestinian negotiations ceased and, by September, the second *Intifada* had begun. As of yet, international attempts to resolve the conflict have failed.

2.2.2 The Humanitarian Situation

The escalating crisis in the West Bank and Gaza has had drastic repercussions for the region's humanitarian situation. Tightened Israeli security has meant restrictions on the movements of people and goods, which has directly impacted regional poverty levels. These restrictions have limited Palestinian employment opportunities, reduced food access, and obstructed health service delivery and education. Furthermore, the Palestinian economy has been crippled by Israeli road barriers which restrict the export of manufactured goods and produce.

According to recent Bank estimates, within the Palestinian territories unemployment has been as high as 45 percent, and 60 percent of the populations in Gaza and the West Bank live below the poverty line.[14] This impoverishment is reflected in the significant drop in Palestinian real per capita food consumption, which has declined by 30 percent since September of 2000. Statistics show that by the end of 2002, Real Gross National Income (GNI) was 38 percent less than it had been in 1999. Furthermore, between 2000 and 2003 alone, the population of the West Bank and Gaza increased by 13 percent. This dramatic population growth, coupled with the region's current economic constraints, has lead to real per capita incomes that are now 46 percent lower than in 1999.[15]

For the health sector, these economic and physical constraints have meant an increased number of women giving birth at home, decreased access to immunizations, and road blocks and curfews which prevent the ill from reaching hospitals. Poor sanitation in refugee camps has contributed to the high percentages of infant (12%) and child (20%) deaths due to acute diarrhoea.[16] Furthermore, between September of 2000 and May of 2003, more than 2,400 Palestinians were killed and 28,000 injured as a result of the conflict, and since 1967 more than 400,000 have been detained or imprisoned. A study conducted by the Gaza Community Mental Health Program (GCMHP) showed that a substantial number of released prisoners reported torture during imprisonment (Table 2).[17] According to the GCMHP, of those surveyed, 41.9% acknowledged difficulty in readapting to life outside of prison, 21% had sexual and marital problems, and 44.7% claimed that they had problems interacting socially. The Palestinian National Authority has used similarly violent measures in the detention of Palestinian members of opposition groups.[18]

Table 2: Incidence and type of torture reported by Palestinian prisoners.

Form of Torture	Percentage of Affirmative Responses[e]
Beating	95.8%
Exposure to extreme cold	92.9%
Exposure to extreme heat	76.7%
Forced to stand for a long period	77.4%
Threats against personal safety	90.6%
Solitary confinement	86.0%

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[e] The study consisted of 477 ex-prisoners who had spent between six months and ten years in the prison system.

Sleep deprivation	71.5%
Deprivation of food	77.4%
Pressure applied to the neck	68.1%
Forced to witness the torture of others	70.2%
Electric shock	5.9%
Instrument inserted into penis or rectum	1.1%

Source: *Trauma, War and Violence. Public Mental Health in a Socio-Cultural Context*, edited by Joop de Jong, 2002.

2.2.3 Current Health Care

In 1995 the total Palestinian population was estimated at approximately 3.5 million. Just three years earlier the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) reported that it had aided around 2.6 million of the Palestinian population who were registered as refugees in areas ranging from Lebanon and the Syrian Arab Republic, to Jordon, the West Bank and Gaza.[19] With its population scattered and a unifying political force lacking, it is not surprising that a Palestinian health policy and strategy, until recently, did not exist.

Health care in the West Bank and Gaza has been supplied mostly by the Palestinian National Authority, the UNRWA, the Palestinian Red Crescent Society, and by private practitioners and NGOS. In 1990 the Palestinian Red Crescent Society and Palestinian heath officials developed a national health plan for the Palestinian population. Among other things, the plan specifically called for the development of a mental health program.[20]

2.2.4 The State of Mental Health

As indicated by its place in the Palestinian National Health Plan development goals, mental health is a rising concern for Palestinians. According to the WHO, there has been an increase in behavioural disorders among youth, who account for 69 percent of Palestinian casualties in the conflict. The Palestinian Ministry of Health's 2002 Annual Report presents a mental disorder incidence rate of 38.2 per 100,000 population. Though statistics reveal a 2.5 percent drop in the number of newly reported cases between 2001 and 2002, the MOH asserts that this difference is due to "difficult accessibility for mental health clinics" and that the number of Palestinians needing treatment is actually higher than these figures reflect.[21]

PTSD is common among Palestinian torture survivors. Though positive coping strategies can develop, the symptoms of PTSD are generally negative, in direct proportion to the severity of the torture,[22] and affect the entire social structure. Ex-prisoners often experience depression, anxiety, and psychosomatic illness which may manifest itself as hostility toward family members. Palestinian women are frequently in a position in which they must deal with violence from or loss of men in their families, while taking on the new and stressful role of sole provider. Many children, furthermore, have witnessed the apparent powerlessness of their parents and are left with little hope for the future. According to the Union of Palestinian Medical Relief Committees (UPMRC), 25 percent of Palestinians would benefit from psychological treatment, necessary as a result of the stress of conflict, political tension and economic distress.[23] Table 3 summarizes studies that illustrate the psychosocial and mental health consequences of the current conflict situation for Palestinians.

Table 3: Summary of studies of the psychosocial and mental health consequences of conflict on Palestinians.

Author	Summary Results
Thabet and Vostanis (2000)	In a longitudinal study, a dose response was found in children, with respect to PTSD. The presence of moderate to severe PTSD at follow-up is best predicated by the total number of traumas experienced by the child at the initial assessment.
Baker (1990)	Effect of violence on 796 children: 80% fighting each other 25% exhibited destructive behaviour 33% suffered from headaches 43% felt depressed
Qouta (2000)	Children 11-12 years showed that the more traumatic experiences they had and the more they participated in the Intifada, the more concentration and attention memory problems they had. 25% of Palestinian children in Gaza had psychogenic fits (Abu Hein et al., 1993).
Gaza Community Mental Health Programme (GCMPH)[24]	32.4% of a random sample of 16-60 year olds in Gaza suffered from stress related psychiatric disorders: 12.5% anxiety 8.3% depression 10.7% psychosomatic disorders 3.2% paranoia
GCMHP[25]	Significant increase in mental disorders and symptoms of PTSD: 99.2% of study group homes had been bombarded 96.6% of children witnessed shootings 54.6% of children were starting to develop acute PTSD 24.6% of mothers had depression

Source: *Trauma, War and Violence. Public Mental Health in a Socio-Cultural Context*, edited by Joop de Jong, 2002.

Despite the clear need for interventions, mental health remains one of the least developed segments of the health sector. Though the West Bank and Gaza each have one psychiatric hospital, they are understaffed, have few beds, and there are limited community-based services to compliment them. Furthermore, few interventions have focussed on the mental health needs of children, and those that have are mostly provided by NGOs and early child education programs. One clinic, part of the El-Rimal PHC Clinic in Gaza, caters specifically to the needs of children, but is only open two days per week.[26]

2.2.5 Mental Health Interventions

Integrating mental health services into the health care system in the West Bank and Gaza means incorporating them in primary, secondary and tertiary levels of treatment. At each level the mental health system must incorporate the essential elements of PHC, including policy and standards, referral, coordination, support supervision, monitoring, evaluation, and health management information systems (HMIS). Furthermore, as the primary providers of care, the Government, UNRWA, and NGOs must all play a role in mental health's integration and maintenance within the system.[27]

The key stakeholders in the area of mental health in the West Bank and Gaza include the Ministry of Health, the Ministry of Education, the Ministry of Social Welfare, WHO, the GCMHP and the Italian and French Governments. The MOH has committed to making mental health a priority and recently established a Rehabilitation of Disabilities Committee to deal with physical, sensory, and mental disabilities. The Ministry of Social Welfare provides support to the indigent, 60% of whom are believed to suffer from mental health disorders. Meanwhile, the Ministry of Education has incorporated new aspects into early child education instruction to train teachers to provide extra support for troubled children and use art and story telling to help them express their emotions.

The WHO is taking the lead in providing advice and support for the review of a Mental Health Policy and its implementation, and has supplied a consultant to work with the Palestinian Ministry of Health to assist in this process. The Italian Government is to provide support for the capacity building of personnel and for the de-institutionalization of mental health services, and plans to organize Palestinian observational visits to Trieste, Italy to demonstrate how a fully community-based mental health service functions. The French Government is involved in building the capacity of mental health professionals within Gaza and the West Bank by training psychiatrists in France, and teaching primary health care workers to recognize and manage common mental health problems.

In addition, eight Community Mental Health Clinics have been established, though tertiary level hospitals still lack critical resources and there are no mental health activities at the district level. Furthermore, NGOs involved in mental health counselling remain largely unregulated, though they have begun the process of developing standards.[28]

2.2.6 The World Bank's Role

Looking at the interventions as a whole, a major gap appears in the area of children's mental health services. A role for the Bank, therefore, is in providing support to the development of a mental health and psychosocial program that can be integrated into the educational system. A brief outline of the strategy includes:

1. Developing the training of trainers course curriculum and related materials;

2. Training core trainers;

3. Trainers training teachers in a cascade fashion;

4. Teachers providing listening and helping skills to the children under their care, with referral for those who need more intensive help;

5. Providing regular support supervision and refresher training;

6. Concurrently, supporting the establishment of Children's Mental Health Clinics (one for Gaza and another for the West Bank). Support would include identifying an appropriate space and furnishing it with appropriate furniture and aids necessary for consulting with children. It may also be necessary to develop guidelines for the management of common mental disorders among children and provide support for the training of medical officers and nurses manning the primary health care clinics.

7. Investing in awareness raising through TV and radio programs to spread knowledge relating to mental disorders and psychosocial consequences of conflict among children, and highlight where services can be found;

8. Possibly also developing programs for parents to compliment the school-based programs to ensure continuity of care between home and school;

9. An essential component of the interventions should be documenting and evaluating their process and impact. It would thus be necessary to begin with a baseline assessment of the situation, develop indicators for monitoring process and impact, and carry out an evaluation at the end of the project period. This would contribute to the much needed knowledge gap on psychosocial and mental health interventions for populations affected by conflict.

The above interventions are important for Palestinian mental health because they fill a gap in the organization of services for those affected by conflict in the West Bank and Gaza. Studies have indicated the extent to which children are affected by the perpetual conflict, yet limited interventions have specifically targeted their needs. An investment in the wellbeing of children is an investment in peace and development for Palestinians.

Because of its past experience in the area of the rehabilitation and resettlement of ex-combatants in Mozambique, Sierra Leone, Rwanda and Uganda, the Bank is well equipped to carry out the interventions. More specifically, the Bank has provided support to innovative approaches for ECD in the post-conflict situations in Rwanda and Burundi. The Bank's involvement in the West Bank and Gaza would build on these experiences, filling a current void in mental health programming. The proposed measures would also compliment the efforts of the partner organizations mentioned above.

2.3 Case Study II: Sierra Leone

General Statistics[29]

Population:	5.2 million
Population growth:	2.0%
Life expectancy:	37.4 years
GNI per capita:	140 US$
GDP:	782.9 million US$
Infant Mortality Rate:	165
Crude Death Rate:	30

2.3.1 Historical Background

As early as 1495 the Republic of Sierra Leone served as an important European trading post for gold, spices, ivory and humans,[30] and by the late 1770s it was a frequent re-entry point for freed slaves returning to Africa. Despite persistent clashes between the British, former slaves, and the region's local inhabitants, Sierra Leone became a colony of Britain in 1792 and remained part of Britain's West African empire until it gained independence in 1961.

In its early years of independence, multi-party elections were held to determine who would lead Sierra Leone. By the late 1960s, however, a contested election followed by a series of coups led to Siaka Steven's ascension to the office of Prime Minister and, soon after, the constitution was altered to disband all political parties other than his All Peoples Congress (APC). Stevens ruled Sierra Leone until 1985, when he personally named Major General Joseph Saidu Momoh as the APC candidate to succeed him. Momoh re-established a multi-party system in 1991 as APC leadership became increasingly corrupt. During the same time period, the Revolutionary United Front (RUF) became active in the region, brutally attacking villages in eastern Sierra Leone. The next nine years were marked by successive coups and attempts to control the RUF. After a largely tumultuous decade, democratically elected President Kabbah, a former UNDP official, declared the civil war officially over in early 2002.[31]

The Lome Accord of 1999 laid the groundwork for establishing the Truth and Reconciliation Commission, which opened a forum for the discussion of human rights violations committed during the civil war. Though the initial agreement provided amnesty to all combatants, the UN added the qualification that perpetrators of war crimes, genocide, and crimes against humanity be brought to justice. The UN currently provides peace keeping support (UNAMSIL) in Sierra Leone and has assisted the Government in establishing a special court to try perpetrators of severe crimes.

2.3.2 The Humanitarian Situation[32]

One-third of Sierra Leonean children will die before their fifth birthdays, a fact which translates into the highest under-five mortality rate in the world.[33] World Health Organization research further shows that children born in Sierra Leone in 1999 have an average healthy life expectancy of only 25.9 years.[34] According to the WHO, a combination of factors contribute to the poor health of Sierra Leoneans, including the HIV/AIDS epidemic, tuberculosis, malaria, child pneumonia and diarrheal disease, and conflict.[35]

Ninety-four percent of households surveyed by the Physicians for Human Rights reported a family member subjected to one or more extreme forms of trauma.[36] Sierra Leone's civil war led to the displacement of as many as half of the country's total population, 50,000 deaths, 100,000 victims of amputations, and a wide range of atrocities perpetrated against the civilian population by both sides. Systematic rape was used as a tool of war. Women and girls frequently were kidnapped to serve as slaves, and those who resisted were beaten, mutilated, or killed. As a result of the abuses, many women have become infected with sexually transmitted diseases and, those who managed to escape from their captors, face stigmatization and estrangement from their families. Rape victims who became pregnant often raise their children alone, suffering from constant fear that the perpetrators will return to claim their babies. In addition, throughout the war Sierra Leonean children were abducted, made to undergo torture and watch the abuses of friends and family members, forced into service as soldiers, and commanded to perform amputations and murders. In May of 2000, one quarter of the troops fighting for the Sierra Leonean Government were under eighteen years of age.

The United Nations Development Index for 2001 cited Sierra Leone as the least developed country in the world. Though the war has officially ended, its physical and psychological consequences linger at all levels of Sierra Leonean society. Much of the country's infrastructure has been destroyed, complicating aid attempts. Furthermore, the RUF is still in power in some regions of Sierra Leone and, in these areas, human rights violations persist.

2.3.3 Mental Health

During their extensive work in Sierra Leone, Physicians for Human Rights found that most of the population suffer from acute signs of distress manifested through physical, cognitive, emotional and/ or behavioral symptoms.[37] Their August 2001 survey of 991 Sierra Leonean women supports this assertion, confirming that most considered their overall health (89%) and mental health (94%) as only 'fair' or 'poor,' 28% had experienced suicidal thoughts or feelings, and 3% had attempted suicide.[38] Data from the Ministry of Health and WHO further shows that more than 100,000 Sierra Leoneans over 12 years of age are severely depressed, an additional 50,000 are psychotic, and 200,000 report some form of substance abuse.[39]

Despite the high level of psychological trauma in Sierra Leone, the Kissy mental hospital, and its one Psychiatrist, Dr. Edward Nahim, provide the only official mental health care in the country. Saudi Arabia's Islamic Development Bank recently granted the hospital a $2 million (US) loan, but the country's mental health issues are too vast to be dealt with at Kissy alone.[40] Similarly, though a number

of regional NGOs also provide psychosocial services, most of their interventions are specific to certain target groups, are not country-wide, and have limited documentation.

Perhaps part of the reason the mental health system has been slow to develop in Sierra Leone is related to the widespread stigma and misunderstandings that are often associated with mental illness in Africa. When 1911 randomly selected Sierra Leoneans were asked for the cause of mental illness only 7 percent cited "illness of the brain" and 11 percent responded "war experiences". Instead, 25 percent blamed mental illness on drugs and alcohol, 16 percent on "God's Will" and 10 percent on "spirits, curses or demons".[41] According to Soeren Buus Jensen, Senior Mental Health Advisor for the WHO in Sierra Leone, "The lack of comprehensive mental health care is significant in contributing to a vicious cycle" of stigmatization.[42]

Another obstacle to adequate mental health treatment in Sierra Leone pertains to the current lack of legislation protecting women's rights. Despite widespread sexual violence, few rape cases have made it to court and only one has resulted in prosecution. Reasons for this lack of support range from government instability to a general aversion to public discussion of sexual issues.[43]

2.3.4 The World Bank's Role

In 1993 the Government of Sierra Leone established a National Health Policy (NHP) to address the country's poor health conditions and inadequate medical resources. By 1994 the National Health Action Plan (NHAP) had been developed to operationalize the NHP. A subsequent World Bank Appraisal and Mid-Term Review Mission, however, showed that the initial objectives of the HNP and NHAP were too ambitious for the circumstances and failed to adequately address the health needs of a post-conflict society. The revised objectives aimed to meet the most immediate needs of Sierra Leoneans by (1) dealing with major public health issues such as sexually transmitted infections (STIs), HIV/AIDS, malaria and onchocerciasis and other infectious diseases; (2) providing care to amputees and psychologically traumatized women and children; and (3) reforming the health system.[44] The estimated cost of the five-year project was $138.1 million to be financed as follows: $63.2 million from the Government of Sierra Leone, $20 million in IDA credit, and $55 million from other donor agencies.[45]

With regard to mental health, the goal of the revised NHAP was to strengthen "mental health services at [the] central level and in districts to provide counseling, support and treatment to war victims and other mentally ill persons." The project successfully completed a number of interventions, including: minor rehabilitation of the Kissy mental hospital; training mental health workers; recruiting counselors to be dispatched to displacement camps; identifying and providing psychiatric services to ex-combatants, traumatized women and children, amputees, communities, and demobilized populations; producing information, education and communication regarding mental health; and providing drugs, prostheses, and equipment.[46] The WHO has been active in supporting the development of a Mental Health Policy.

A joint World Bank/ Department for International Development (DFID) mission in the summer of 2002 assessed Sierra Leone's mental health needs from the perspective of legal and judiciary reform. Florence Baingana, Senior Health Specialist (Mental Health) for the World Bank traveled to Sierra

Leone to assess the feasibility of integrating mental health components in the Legal Aid Clinics, Peace and Reconciliation activities, and any other identified areas. Baingana also evaluated the organization and capacity of the mental health services and programs available in Sierra Leone and their ability to provide support to and be a referral point for the Legal Aid Clinics. In her assessment, Dr. Baingana argued that psycho-social support needed to be provided for victims of violence during legal proceedings in order to make prosecutions possible and facilitate the reconciliation process. She also acknowledged the importance of combating mental health stigma, suggesting that public awareness should be raised and treatment be made less conspicuous through their incorporation in primary health care. Other recommendations included:

❑ The formation of a mental health coordinating committee;

❑ Strengthening and mainstreaming cross-support of training, including standardizing manuals and regulations, and setting guidelines;

❑ Providing support to NGOs involved in psychosocial work in order to strengthen their activities;

❑ Encouraging linkages between the DFID supported Family Support Units of the Sierra Leone Police, Legal Aid Clinics, and NGOs providing psycho-social support;

❑ That the WHO policy project use this opportunity to convene various, relevant stakeholders so they all participate in the formulation and implementation of a mental health policy.

❑ Since mental health has been included as a priority in the Draft Health Policy, it is hoped that this will be endorsed and that the Policy will be translated into a strategy document with activities, timeline and a budget.

❑ The WHO's support of the development of the Mental Health Policy is highly commendable. This hopefully will lead to the development of a strategy document and will stimulate the participation of other partners in its implementation.

4. EARLY CHILD DEVELOPMENT (ECD)

3.1 Theoretical Basis: the Link between ECD and Mental Health

ECD is "the process of change in which the child comes to master more and more complex levels of moving, feeling and interacting with people and objects in the environment."[47] Early childhood spans the period from birth to approximately age eight and is the most rapid period of human development, during which learning is done through "doing". Studies show that the first three years, especially, are crucial for the growth and development of the brain and that lack of stimulation may lead to a 20 to 30 percent reduction in brain size.[48] Occurrences in this early period of development directly impact future physical and mental health, learning and behavior.[49]

In April of 1996 the World Bank organized the conference *Early Child Development: Investing in the Future* and invited a variety of participants from around the world to focus on the needs of children. During the gathering a list of critical components for child development was established and endorsed by the Bank, WHO, UNICEF, and an array of participating NGOs. According to the list, efforts to support children's healthy development depend on:

- ❑ A healthy mother who receives adequate food, antenatal care and attention to her needs during pregnancy;

- ❑ A safe delivery, with proper obstetric care and back-up;

- ❑ Immediate and exclusive breast-feeding, for intensive mother-child interaction, bonding, and the timely introduction of regular feeding;

- ❑ Timely and appropriate preventive and basic health care;

- ❑ Proper nutrition and micronutrients;

- ❑ Caring interaction with family and other adults, including age-appropriate play, protection from accidents and environmental dangers, including access to safe water and sanitation facilities;

- ❑ Preschool and peer interaction, with adequate adult care and supervision, in an environment conducive to learning and to nurturing effective peer relationships;

- ❑ Timely enrollment and attendance in an appropriate primary school leading to attainment of age-appropriate skills;

- ❑ Access to basic preventive and curative health and nutrition measures throughout childhood.[50]

Studies show that children involved in well-planned ECD programs have increased chances for future academic success, increased verbal and intellectual development, and better social and emotional skills-[51] all of which contribute to better mental health.

3.2 ECD in the Context of Sub-Saharan Africa

For many of Sub-Saharan Africa's (SSA) children, health interventions performed at the primary school level are already too late to protect them from lifelong debilitation and disease. According to

one World Bank report, "Many of the same conditions of poverty that previously placed the under-5 at risk of death later leave them at risk of poor health, malnutrition and impaired mental, social and emotional development."[52] Only 46 percent of SSA children receive the appropriate immunizations,[53] almost one third face chronic malnutrition, and less than 50 percent will enter primary school.[54] Due to current conditions of poverty, neglect, and conflict, early childhood interventions are critical for SSA.

3.3 Case Study: Burundi

General Statistics[55]	
Population:	7.1 million
Population growth:	2.0%
Life expectancy:	42 years
GNI per capita:	90 US$
GDP:	720 million US$
Infant Mortality Rate:	110
Crude Death Rate:	21

3.3.1 Historical Background

As early as the 16th century Burundi was ruled by a Tutsi Monarchy that protected the populace in exchange for tributes and taxes. In 1899 Germany annexed Burundi into its East African territory, but after the First World War, the League of Nations passed administrative responsibility for the Ruanda-Urundi region (later Rwanda and Burundi) to Belgium, which governed the territory indirectly through the existing monarchy.

When Burundi became independent in 1962, Tutsi King Mwambutsa IV set up a constitutional monarchy with equal Tutsi and Hutu representation. However, a series of assassinations, government crack-downs, and subsequent revolts kept the region volatile until the mid-1970s, then again during parts of the 1980s. When the first democratically elected president, Hutu Melchior Ndadaye, was assassinated in 1993, tensions once more flared between the ruling Tutsi and majority Hutu. Since 1993 alone, approximately 200,000 Burundians have died as a result of severe ethnic violence, and hundreds of thousands have become displaced within Burundi or are refugees in neighboring regions.[56] In 2001 steps were taken to form a transitional government which was led by Tutsi, Pierre Buyoya, and Hutu, Domitien Ndayuizeye, for the initial 18 months, and Ndayuizeye and Alphonse Marie Kadege during the subsequent year-and-a-half. The current government is working to establish a system for democratic elections and reach an agreement with rebel factions that have not yet signed the 1999 Arusha Peace Accords. Elections are planned for sometime before November of 2004.[57]

3.3.2 The Humanitarian Situation

As a result of political turmoil in the 1990s, international donors withdrew funding from Burundi and the Government shifted its spending away from social needs in order to increase investment in the military. Between 1996 and 1999 countries within the region imposed their own economic sanctions on Burundi in order to force the Government to return to a constitutionally based system of administration.[58] Already one of the eight poorest countries in the world according to 1991 per capita GNP levels,[59] these measures pushed Burundi deeper into crisis. By the middle of 1996 Burundi's GDP had decreased by 21 percent and inflation was high. Under these conditions, poverty grew by as much as 80 percent between 1993 and 1999, and rates of malnutrition and endemic disease increased by at least 14 and 200 percent, respectively. Furthermore, primary school enrolment was below 30 percent in four of Burundi's sixteen provinces, and was at 9 percent in one of the most conflict affected areas.[60] According to local NGO and World Bank partner Twitezimbere, these conditions have led to a significant number of Burundian children showing weak physical, psychological, social and emotional development.[61]

3.3.3 The World Bank's Role

Analytic
Some of the World Bank's work in Burundi has been analytic. The Statistical Institute and Economic Surveys of Burundi included 12 mental health questions on the 1998 national Burundi Priority Survey, which were adapted from the General Health Questionnaire (GHQ-12), used worldwide to gauge mental distress. In 2002 the Core Welfare Indicators Survey was conducted, again including the GHQ-12, as well as the AUDIT (Alcohol Use Disorders Test). In the 1998 Survey, the GHQ-12 questions were adapted to suit the context of Burundi, while the 2002 Survey used the actual GHQ-12 and the AUDIT, translated from French, into Kirundi and back into French.

Preliminary results are available for the 1998 study, which consisted of 5599 participants, 10 years of age and above. Five answer choices were provided for each of the GHQ-12 questions, and participant responses were scaled to create an "index of distress", with lower numbers reflecting higher distress. According to the results, Burundi levels of distress mirror those in other conflict affected areas. Almost one third of respondents were distressed, when the cut-off was set at 3, while 20 percent of the population were assessed as distressed when the cut-off was set at 2.

The data further showed that rural populations from the mountains, which were most affected by the conflict, were more likely to suffer from high levels of distress than urban populations. The distressed were twice as likely to be sick and, more likely not to be working. The study supported the relationship between poverty and distress, revealing that distress was significantly higher in the lowest seven deciles than in the top three. Finally, children living in households with a distressed head were significantly less likely to attend school, and the effect was greater for males than for females. A full discussion paper regarding the study's findings is to be published in fiscal year 2005.

Operational
In addition to the above research, the Bank also supported a Social Action Project with an ECD component which focused on 1) child health, 2) cognitive development, and 3) nutrition, The ECD project began in 2000 with the formation of "Circles of Mothers" at each village level in 4 pilot

communes. Each Circle then identified all the children in the village aged 3-6 years, who were recruited into an Early Child Center. Burundian psychologists assessed the literacy level and child development knowledge of 2 local mothers (Monitors) per village and, based on their findings, authored a training package complete with a teacher handbook and educational aids.[62] Psychosocial project targets included improving community participation in the delivery of services for the psychosocial and cognitive development of children, identifying children in need of special care and protection (i.e. orphaned, traumatized, and physically disabled children), and setting up an appropriate referral system to meet their needs.[63] The project is being implemented by Twitezimbere.

A review of the Project in 2003 showed that 34 communes have been reached with the ECD program. 196 pre-school circles have been created, 564 monitors trained who are reaching 16,451 children. This is three times the number currently enrolled in formal pre-school programs. It was noted that "children who participated in the pre-school circles tend to perform better in the first year of school".[64]

4. MENTAL HEALTH IN PRIMARY HEALTH CARE (PHC)

4.1 Theoretical Basis: Why Mental Health Considerations are Critical to PHC

Though the disability caused by mental disorders is high worldwide, developing countries have substantially fewer resources to help them cope with the burden. While high income countries have an average of 8.7 psychiatric beds per 10,000 population, low and lower middle income countries have only .24 and 1.4, respectively. Low income countries also lack the number of mental health professionals which high income countries possess, as seen in the dramatic difference between the number of psychiatrists (.06/ 9.0), psychiatric nurses (.16/ 33.5), psychologists (.04/ 26.7), and mental health social workers (.03/ 25.5).[65] The critical need for intervention coupled with the dilemma of limited resources, led the 1974 WHO Committee on Mental Health to conclude that, in order for basic mental health care to reach the populations of developing countries, such care must be provided by non-specialized personnel at all levels of the health care system.

Incorporating mental health in primary health care can lead to a variety of benefits. According to the WHO, these include:

❑ Less stigmatization of patients and staff, as mental and behavioral disorders are being seen and managed alongside physical health problems;

❑ Improved screening and treatment, in particular improved detection rates for patients presenting with vague somatic complaints which are related to mental and behavioral disorders;

❑ The potential for improved treatment of the physical problems of those suffering from mental illness, and vice versa;

❑ Better treatment of mental aspects associated with "physical" problems;

❑ A shared infrastructure leading to cost-efficiency savings, the potential to provide universal coverage of mental health care, and the use of community resources which can partly offset the limited availability of mental health personnel.[66]

The WHO has developed a checklist of components that should be considered in order for mental health's inclusion in PHC to be successful:

❑ General health staff must have the knowledge, skills and motivation to treat and manage patients suffering from mental disorders.

❑ There need to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs at primary and secondary levels.

❑ Basic psychotropic drugs must be available at primary and secondary care levels.

- Mental health specialists required to provide support to and monitor general health care personnel.

- Effective referral links between primary, secondary and tertiary levels of care need to be in place.

- Funds must be redistributed from tertiary to secondary and primary levels of care or new funds must be made available.

- Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities.[67]

4.2 Case Study: Lesotho

General Statistics[68]	
Population:	1.8 million
Population growth:	1.0%
Life expectancy:	37.9 years
GNI per capita:	550 US$
GDP:	714.4 million US$
Infant Mortality Rate:	91
Crude Death Rate:	25

4.2.1 Historical Background

Present day Lesotho evolved around 1820 when Moshoeshoe the Great gathered tribes displaced by the Zulu State's expansion and organized them into a unified force in the mountains of southern Africa. Moshoeshoe and his people- the Basotho- initially warded off British and Boer advances. However, continued Boer attacks led Moshoeshoe to reach an agreement with Britain in 1869, placing the region under British protection. Control passed back and forth several times between the people of Basotholand and the British, but in the mid-1950s the Basotho formally requested independence, which they gained in 1966. Shortly after, Basotholand became Lesotho and it has been a self-governing nation ever since.[69]

The Bosotho have experienced dramatic improvements in health status over the last several decades. Between 1960 and 1997 average life expectancy increased from 42 to 58 years. Furthermore, the infant mortality rate declined from 102 to 77 per 1,000 live births between 1976 and 1997, and communicable disease rates have decreased substantially as a result of increased access to immunizations.[70] Despite these improvements Lesotho faces new health challenges that must be addressed.

4.2.2 Health Care

The health care needs of today's Lesotho are very different than when it gained independence from Britain in 1966 and set about establishing its initial health system. In 1999 the Ministry of Health and Social Welfare (MOHSW) of Lesotho and the World Bank released a report detailing the need for heath sector reform. In the words of the MOHSW, "We could not…anticipate the exponential growth of our population, the devastating effects of AIDS, the re-emergence of tuberculosis as a major health problem, the decline in resources, or the unintended fragmentation of our health system through the very programs that helped improve health status to begin with."[71]

When Lesotho's democratic government came to power in 1993, the Ministry of Health organized a health strategy development workshop to address shortcomings in the existing health care system. Through this measure, the National Health Sector Plan (1995-2000) was developed and six aspects of the health sector were identified for development and reform, including financing, human resources, service decentralization, creation of a district health package (to bring health services to all Basotho), a safe and effective supply of pharmaceuticals, and better coordination of donor efforts. The overall goal of these initiatives was to establish a health system with universal access, social justice, and equity. [72]

Lesotho's government and a variety of religious groups represented by the Christian Health Association of Lesotho (CHAL) are the primary health providers within the country. In 1999 the African Development Bank and the Government of Lesotho co-funded a study aiming to complement the Health Sector Reform initiative by:

(1) Focusing on health service delivery in the Christian Health Association of Lesotho (CHAL) managed Health Service Areas (HSAs);

(2) Strengthening human resource development for the sector as a whole;

(3) Further developing national mental health service delivery capacity;

(4) Strengthening national maintenance systems for biomedical equipment, plant and transport.[73]

The study was divided into three phases, the first of which involved extensive data collection and analysis, and led to recommendations for the development design put forward in phase two. In regard to mental health, phase two specifically called for:[74]

> Extending the capacity of the Ministry of Health and Social Welfare to cost-effectively meet the mental health service needs of the Basotho population through strengthened integration with PHC and further development of specialist mental health services coupled with improved management and more complete intersectoral collaboration. The principle objectives envisaged include: (a) strengthening public mental health programs, (b) strengthening the integration of mental health into primary health care, (c) strengthening the national referral system for mental health care, (d) strengthening specialist mental health services at Mohlomi Hospital, (e) strengthening the management capacity and functions of the Department of Mental Health, and (f) strengthening intersectoral collaboration in the provision of mental health services.[75]

The World Bank's International Development Association (IDA) has pledged to contribute technical support and $6.5 million in credit for Lesotho's Health Sector Reform Project, while another $13.9 million will come from the Lesotho Government and other donor organizations.[76]

4.2.3 Mental Health

A 1990 study conducted by Michael Hollifield, et al. into the mental health of the Basotho revealed that 12.4 percent of the survey population had major depression, half of whom also experienced panic disorder. Another 4.2 percent had panic disorder alone and 6.2 percent suffered from generalized anxiety disorder. Furthermore, 16.6 percent of the population surveyed had either major depression, panic disorder or both.[77] When compared to epidemiological study data of U.S. mental health, Hollifield et al.'s work demonstrated that the prevalence of these disorders was significantly higher in Lesotho.[78] The study further showed that, though no respondents claimed that traditional healing was the best option for dealing with panic attacks, 23 percent of those affected had at some point sought a traditional healer for help.

Hollifield et al. put forward two theories to explain the high prevalence of psychiatric disorders in Lesotho. First of all, the majority of psychiatric disorders in Lesotho are left "untreated" by western standards in that almost no patients are treated with conventional antidepressants or anxiolytics. Furthermore, research shows that "harsh environmental experiences" lead to depression and that there is a "linear relationship between severity of depression and the number and severity of adverse experiences."[79] For Lesotho, a variety of factors contribute to the harsh environment. Though as recently as 1950 Lesotho was the "granary for Southern Africa", today it produces only 40 percent of its own food[80] and is one of the poorest nations in the world.[81] As a result of current economic conditions, as many as 50 percent of Basotho males age 20-39 make their livings working in South African mines, which has lead to separated families and destroyed social networks.[82] Another 35 percent of Lesotho's labor force is un- or under-employed.[83]

4.2.4 The World Bank's Role

In November of 2001 World Bank Mental Health Specialist Florence Baingana travelled to Lesotho to participate in the Lesotho Health Sector Reform Project Annual Review. While in Lesotho, Dr. Baingana's primary tasks were to provide support to the strengthening of mental health activities, especially issues pertaining to mental health policy development, community needs assessment and mental health's inclusion in the District Health Package.

According to Baingana, a variety of mental health reforms have already been implemented and the framework for integrating mental health into primary health care is in place. Mental health is not only one of the seven programs specifically supported by the MOHSW, but has been successfully included in the District Health Package and currently receives 4-5 percent of the MOHSW budget (8-10 percent if the mental health components of the district budgets are included). There is currently a national referral, 120 bed hospital, and 9 district mental observation units with 12-14 beds each, and community health workers have been trained in 4 of the 10 districts to recognize and refer patients. Furthermore, systems for vertical support supervision and vertical and horizontal referrals are in place and funded by the MOHSW and the district budgets. Essential drugs are also available.

Despite these accomplishments, in her capacity as a technical advisor, Baingana raised several issues facing further mental health reform:

❑ The lack of an explicit vision, mission and objectives and, hence, strategic plan has resulted in ad hoc annual planning. It is hoped that this will be overcome with the development of the policy and strategic plan.

❑ At the secondary level, psychiatric nurses provide all of the mental health services, but do not have the legal power to prescribe medications. The Mental Health Policy should include a provision for psychiatric nurses to prescribe and should be followed up with the relevant legal provisions. The feasibility of this could be one of the areas assessed in the Community Needs Assessment or as part of the process of developing the Mental Health Policy.

❑ Secondary level medical officers could also receive three months of mental health orientation. This is proposed as a result of MOs not providing support to psychiatric nurses at the secondary level and not feeling comfortable seeing mental health patients.

❑ The development of standards and guidelines is an essential component for the implementation of health policy and the regulation of services, especially when a variety of stakeholders and cadres of health workers are involved. It is hoped that the development of standards and guidelines and their dissemination will be part of the mental health policy development and implementation process. Guidelines developed for each level of health worker must be consistent with the training curricula development process, where it is envisaged the NHSC will take the lead role.

❑ There is a distinct need to establish more lower level rehabilitation services. Children with impaired vision and hearing have very limited access to community-based, inclusive education. It is also necessary to develop inclusive educational services for those who may have learning disabilities, including mental retardation.

❑ At present, psychiatric nurses visit schools on request to evaluate students suspected of having mental disorders. A plan for sensitizing teachers to mental disorders and training them to appropriately refer children for help is currently in the Teacher Training College curriculum. Though there are no present facilities for school counsellors, this is another area where a linkage with the Ministry of Education could lead to the training of teachers as counsellors so they can provide initial interventions (listening and helping) for some of the emotional problems found, especially in adolescents and pre-adolescents.

❑ A tertiary level unit is planned for Mohlomi Hospital to provide mental health care for the elderly. There are presently no services for the elderly at lower levels. In order to build on this initiative, a study should be conducted on the feasibility of setting up community-based support systems for the elderly or establishing smaller, home-like settings where they could be looked after closer to home. Due to its current demographic transition, Africa will soon have a big population of elderly who may need services. Though the Government of Lesotho should be

commended for thinking ahead in relation to the elderly, it is critical to study the most feasible and cost-effective system relevant to the context of the country.

❑ Collaboration both within the MOHSW and outside the Ministry needs strengthening. The MOHSW may want to think about convening the various stakeholders in mental health care provision and promotion to form a "coordination committee". The Committee could include the Directors for Mental Health, PHC, SW, Health Education, NHSC, representatives from the Ministry of Education, key NGOs providing care, and NGOs of consumers of services. With the guidance of a consultant, the Committee could take the lead in developing the Mental Health Policy. The same committee could then develop the Strategic Plan and participate in overseeing its implementation.

❑ Special areas of concern such as children's mental health, the mental health of women, and alcohol and drug abuse need strengthening. They would be a part of the policy and strategic plan, once developed.

5. ORPHANS AND VULNERABLE CHILDREN

5.1 Theoretical Basis: the Effects of Childhood Vulnerability on Mental Health

Children are vulnerable to a number of factors that may hinder their social, physical, and mental wellbeing and development. Foremost among these influences is poverty. Women and children comprise 80 percent of the world's poor, and children from the poorest quintile of the population are twice as likely to die before age five than their counterparts in the richest quintile.[84] Two million of these children die yearly from diseases that could be prevented with vaccines costing as little as US$1 per child.[85]

Those children who survive face a multitude of barriers to safety and security. Each year the births of 50 million children go unreported, a phenomena which leads to missed opportunities for health care, education, and immunization and lost protection against premature entry into the military, labor force, and marriage.[86] At any given time in the world over 300,000 child soldiers are fighting in more than 30 countries, 40 million children under 15 are abused and neglected, one million children are being held in detention facilities, 246 million are forced into labor, and 2 million are used in prostitution or pornography.[87] Another two million children have died since 1990 as a result of armed conflict, while 6 million others have been seriously maimed or injured.[88] Moreover, the number of orphans and vulnerable children (OVC), and magnitude of their vulnerability is increasing as a result of the spread of poverty, HIV/AIDS and violent conflict. The subsequent over-saturation and destabilization of traditional child protection mechanisms is further eroding their chances for healthy survival.[89]

Due of the widespread nature of child vulnerability, World Bank Child Protection Specialist Anne Kielland has developed an operational definition for OVC, stating that they are "the children who, in a given local setting, are most likely to fall through the cracks of regular programs and therefore need to be given special attention when such programs are designed and implemented."[90] She further narrows the classification by defining typical OVC family structures and core types. According to Kielland, OVC are children who are orphans, separated from their parents, live with troubled parents, or have extreme needs that normal families alone cannot meet. OVC generally live on the street, are affected by HIV/AIDS or armed conflict, suffer from a disability or chronic illness, or are involved in an especially harmful form of child labor. These children, between the ages of 0 and 15, are the ones especially susceptible to risks such as:

- Infant, child and adolescent **mortality**;
- Low immunization, low access to **health** services, malnutrition, high burden of disease;
- Low **school** enrollment rates, high repetition rates, poor school performance and/ or high school drop out rates;
- Intra-household **neglect** vis-à-vis other children in the household (reduced access to attention, food, care);
- Family and community **abuse** and maltreatment (harassment and violence);
- Economic and sexual **exploitation**, due to lack of care and protection.[91]

5.2 Case Study: OVC in Sub-Saharan Africa

5.2.1 An Overview

According to World Bank estimates, as many as 60 million children in Sub-Saharan Africa, 20 percent of the total SSA child population, fit the OVC profile outlined by Kielland.[92] While a variety of factors have fueled these high numbers, armed conflicts and the spread of HIV/AIDS are two of the strongest contributors. Almost a third of the 48 countries in SSA are currently or have recently been involved in conflicts.[93] As a result, throughout the past decade approximately 150,000 children in SSA have been orphaned[f] and 500,000 have been separated from their parents, while another 500,000 live with parents who are "dysfunctional" as a result of the widespread brutalities.[94] Furthermore, around 120,000 children under age 18 are currently fighting in conflicts within Africa, some as young as 7.[95]

The children of SSA have also experienced dramatic consequences as a result of the AIDS epidemic. While in the years before its spread only 2 percent of African children were orphaned,[96] the rate is now as high as 17 percent in some countries.[97] For Africa, this translates into over 12 million AIDS orphans in 2000,[98] and a projected 35 million orphans by 2010.[99] In addition, one-third of children born to a mother infected by HIV/AIDS will, themselves, be infected by HIV through childbirth or breastfeeding. At present, three million SSA children under age 15 have HIV/AIDS and,[100] even those who are HIV free, face stigmas which hinder their adoption and protection.[101]

In light of these circumstances, the dependency ratio in most African countries is approaching or greater than one, meaning that there is approximately one dependent for every potential worker between the ages of 15 and 64. Due to the spread of AIDS, the ratio will grow as the number of orphans increases and productive workers decrease.[102] Almost one third of 5 to 14 year olds are already in Africa's labor force, giving Africa the highest proportion of child workers of any region in the world.[103] Of these 48 million workers, around 600,000 are involved in what the ILO terms the "worst forms" of labor, which include trafficking, slavery, prostitution, pornography, soldiering and illicit activities.[104]

5.2.2 Mental Health of SSA Children

According to the WHO, when the daily environment is "inadequate, children often do not achieve their full potential for cognitive, social, and behavioral development."[105] Because OVC live in some of the most "inadequate" environments in the world, they are at a distinct disadvantage for healthy development. Data gathered by UNICEF on the development of children in Burundi shows that children who have lost their mothers or both parents are more likely to be malnourished and, hence, will not reach their full physical or intellectual potentials.[106] Other research reveals that OVC often show physical signs of distress such as "hysteria, crying, insomnia, nervousness, and a general emotional imbalance marked by anxiety, depression and grief."[107] Moreover, children raised in such

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[f] AIDS orphans are defined as HIV negative children who have lost their mother or both parents to AIDS before the age of 15.

destabilized environments may lack trust in others and in an overall system of law, both of which are necessary for creating a stable society in the future.[108]

Though a number of studies have looked at the impact of poor socio-economic conditions on OVC, few have explored the psychological impact of their circumstances. When surveyed, even HIV/AIDS positive Ugandan parents mainly showed concern about their children's future economic situation, and only 10 percent reported that they were worried about their emotional wellbeing.[109] What studies that have been conducted, however, have shown that the psychological impact of orphanhood is substantial. One study carried out in Tanzania compared the psychological health of orphans to non-orphans and found "substantial evidence of reduced psychological wellbeing [for orphans], with most orphans showing psychological impairment, especially internalised behavior changes such as depression, anxiety and low self-esteem…."[110] Other research shows that orphans have "higher tendencies toward social pathology" than non-orphans.[111] The Bank hopes that investment in these children will help reduce the risk of permanent and severe psychosocial and psychological damage.

5.2.3 The World Bank's Role

Analysis
At present, the true magnitude of the OVC problem and the pros and cons of existing strategies to address it are not clearly understood. Moreover, there has been a lack of coordination within countries and between national governments, local NGOs, and international organizations in the pooling of information, resources, and efforts. To address these shortfalls, the World Bank has developed an operational definition of OVC to determine the number of children belonging to this category in order to create interventions specifically targeting them.*[112]* Additionally, in 2001 the Bank issued the paper "Social Protection of Africa's Orphans and Other Vulnerable Children" to delve further into "good practice" program options.*[113]* Besides discussing OVC targeting methods and successful interventions, the paper "traces the sources and extent of vulnerability, examines the prevailing community responses, and argues the case for a concerted public policy response."*[114]*

Operations
The Bank has assisted OVC through its lending practices. In 1998, IDA credit was approved for the Uganda Nutrition/ Early Childhood Development project which, as one of its components, funds community based organizations and women's groups that assist young orphans.[115] In the Eritrea Integrated Early Childhood Development Project, $12 million of the $49 million IDA credit is directed toward aiding post-conflict and AIDS orphans through family reintegration programs and group homes.[116] The Bank has also initiated a multi-country HIV/AIDS program (MAP) which incorporates subsidies aimed at the educational, nutritional and skill needs of orphans in Burundi.[117]

In addition to targeting OVC directly, the Bank also supports the personnel and programs currently working with OVC. *The Early Childhood Development and HIV/AIDS: Helping Communities to Care for Young Children* project, piloted in Rwanda, seeks to develop a prototype for training caregivers in the skills needed to aid the development of HIV/AIDS affected children.[118] The Bank also has used its Social Investment Fund to provide support to traditional community safety nets,[119] which generally bear the brunt of the OVC crisis.

Psycho-Social Interventions: Possibilities for the future

A presentation by World Bank Health Specialist Florence Baingana, at the June 2001 World Bank/ World Vision conference *Orphans and Other Vulnerable Children: What role for social protection*, specifically addressed the psycho-social needs of OVC. Based on experience from psycho-social interventions targeting vulnerable children in Uganda and Burundi, Baingana cited several approaches that may help alleviate the psychosocial problems of OVC. According to Baingana, areas through which the World Bank may offer future psycho-social support include: tracing orphans and other unaccompanied children; resettlement in families and communities; standardized training of counsellors; training of the communities' own resource persons (CORPS), teachers and health workers in counselling skills; general health and education programs; income generation assistance; and strengthening of the co-ordination capacity of the lead agency/ government sector.[120]

6. HIV/AIDS

6.1 Theoretical Basis: The Relationship between HIV/AIDS and Mental Health

6.1.1 Background on the Epidemic

Since its appearance two decades ago, HIV/AIDS has infected more than 60 million people and claimed over 20 million lives.[121] Three million people died from AIDS in 2002 alone, making it the fourth largest cause of death in the world. Furthermore, the global rate of HIV/AIDS infection is continuing to grow. Approximately five million people were infected with HIV in 2002,[122] and another 14,000 infections occur each day.[123]

Though the AIDS epidemic is a global crisis, the degree of its impact varies dramatically for different regions of the world, and developing nations bearing the burnt of the burden. The sheer magnitude of the epidemic in Sub-Saharan Africa has meant it is, by far, the most severely affected by the disease, which is the leading cause of death in the region.[124] In several SSA countries, more than 30 percent of the total populations are HIV/AIDS positive and,[125] as a result of the disease, in some places life expectancy has been reduced by as much as 50 percent.[126] Meanwhile, Eastern Europe and Central Asia currently face the highest rates of new infection. In Uzbekistan there were approximately as many new cases of HIV infection in the first six-months of 2002 as their had been during the entire 1990s, and between 1999 and 2001 HIV/AIDS prevalence grew exponentially in Estonia, increasing from 12 to 1474 cases.[127]

The regions where HIV/AIDS is having its strongest impact are being devastated by the multi-faceted effects of the disease. In addition to deteriorating quality of life for the infected, it is taxing already strained health and social care systems, creating orphans, forcing the poor further into poverty, reducing the workforce, and putting immense pressure on national economies. For some countries, the crisis threatens to undo the development progress which has taken place over the last half a century.[128]

6.1.2 HIV/AIDS and its Relationship to Mental Health

One insufficiently explored aspect of the HIV/AIDS burden is its complicated relationship to mental health. Mental disorders related to cognitive impairment, substance abuse, and personality can influence behavior in ways that lead to a greater risk of HIV infection. Conversely, HIV/AIDS itself can cause a variety of psychological conditions brought on by circumstances, and psychiatric conditions resulting from "the direct action of HIV, opportunistic pathogens or tumours affecting the central nervous system, by the toxicity of antiretroviral drugs, antibiotics or chemotherapy, or by multiple complications of end-stage disease."[129]

HIV/AIDS infected individuals face a number of the same stressors confronted by other chronically ill people, such as long-term discomfort, physical deterioration, and eventual death. Factors like these cause the chronically ill to have higher suicide rates[130] and higher mental disorder prevalence (30-50%) than the general population (15.4- 30%).[131] Unlike many chronic disease sufferers, however, HIV/AIDS patients face the additional stigma, discrimination, and loss of loved ones which often

accompany AIDS. According to Jonathan Mann, former director of the WHO Global Programme on AIDS, the AIDS epidemic entails three distinct phases, including "the epidemic of HIV, epidemic of AIDS, and the epidemic of stigma, discrimination, and denial."[132]

The World Health Organization asserts that the mental health consequences of AIDS are "substantial."[133] In addition to the general emotional responses of "anger, guilt, fear, denial, and despair,"[134] 38 to 73 percent of HIV/AIDS patients will have at least one psychiatric disorder in their lifetimes.[135] In fact, Treisman et al. claim that most HIV positive psychiatric patients actually experience multiple disorders.[136] They classify these disorders in the following four categories:

1. brain diseases
2. personality disorders
3. disorders of motivated behavior
4. problems that emerge from life circumstances

Brain diseases typically manifest themselves in syndromal forms and are caused by structural or functional brain lesions.[137] Autopsies reveal that three-fourths of all HIV/AIDS patients experienced neurological changes, and 30 percent exhibit multiple central nervous system (CNS) lesions.[138] Examples of common, HIV/AIDS-related brain disorders include major depression and AIDS dementia complex (ADC).

Treisman et al. estimate that as many as 60 percent of HIV/AIDS patients suffer from the affective disorder **major depression** at some point during their illness.[139] The disorder may be episodic or chronic, and is characterized by a general loss of satisfaction from activities that were once satisfying, sleep disturbances, overwhelming sadness, and feelings of guilt and self-loathing.[140]

A number of patients also suffer from neuropsychological deterioration as a direct result of the virus. Some degree of cognitive impairment is detected in as many as 50 percent of AIDS patients.[141] **Dementia**, one of the more severe forms of impairment, affects between 6.5 and 20 percent of HIV/AIDS infected individuals, and is characterized by "marked impairment in cognitive functioning, involving the ability to observe, concentrate, memorise, and quickly and flexibly process information."[142] Studies conducted in the United States show that HIV/AIDS is one of the most common causes of dementia among 20 to 59 year olds, but that its incidence can be reduced through proper drug treatment.[143]

Adjustment disorder, or **demoralization**, manifests itself in a similar way as depression but is not a brain disease. Instead it stems from problems related to life circumstances, and must be treated through psychotherapy, not medication.[144] Demoralization generally springs from the strain of chronic illness, societal stigma, and accepting mortality.

Up to 30 percent of HIV/AIDS patients are affected by **personality disorders**[145] which contribute to their behaving in "seemingly irrational and deliberately self-destructive" ways, complicating their treatment and further impairing their health.[146] Meanwhile, 20 to 73 percent of HIV/AIDS infected individuals have a **substance abuse disorder,** often linked to depression, which makes them "prone to have sexual behaviors at risk for HIV transmission, as there is a higher rate of sexual dis-inhibition, impaired judgement, and impulsivity."[147]

6.2 Addressing Mental Health in the Context of HIV/AIDS

In addition to impairing quality of life, studies have shown that the course of HIV infection to AIDS to death progresses faster for those with depression, as evidenced by a rapid fall in CD4 cell counts and an increase in mortality rates. Mental disorders among HIV/AIDS infected individuals also increase the likelihood of risk behaviors which spread HIV/AIDS, and limit the effectiveness of treatment, since many mental disorder sufferers become unable to adhere to their prescribed regimens.[148] Taking these factors into account, it is critical that the mental disorders of HIV/AIDS infected individuals be detected and addressed as early as possible.

To accomplish this, the link between mental health disorders and risky behaviors must be entirely explored and understood, and the psychological and psychiatric conditions caused by HIV/AIDS studied further. In addition, interventions aimed at alleviating these disorders must be thoroughly evaluated to determine their cost effectiveness and practicality. The WHO's HIV Care module, within its Integrated Management of Adolescent/ Adult Illness (IMAI) program, includes a screen for depression in the list of signs and symptoms that nurses are trained to check during HIV/AIDS patient consultations.[149] Treatment for HIV/AIDS patient depression has already been shown to be cost-effective, since it is possible to combine anti-depressants with antiretrovirals. If such efforts could be expanded to a broader scale and directed at more disorders, the negative effects of mental disorders on HIV/AIDS patients could be alleviated. However, though the importance of including mental health components within HIV/AIDS programs is becoming more widely understood, its practice remains limited.

6.3 The World Bank's Role

Since the epidemic began the World Bank has been involved in advocacy, analysis and lending to support countries around the world in their fight against AIDS. Though the World Bank is currently the "largest long-term investor in the prevention and mitigation of HIV/AIDS in developing countries,"[150] its broad array of HIV/AIDS initiatives fail to address mental health. Because of the intertwined nature of HIV/AIDS and mental health, and their mutual impact on development, it is critical that the Bank expand its focus to take mental health into account.

7. VIOLENCE AGAINST WOMEN

7.1 Theoretical Basis: the Relationship between Violence Against Women and Mental Health

7.1.1 Defining Violence Against Women

Though there is no standard definition for the term "violence against women", it is generally agreed that it can take physical, sexual, or verbal forms.[151] The definition put forward in the Declaration and Platform for Action of the 1995 Fourth World Conference on Women in Beijing states:

> The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:
>
> (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non- spousal violence and violence related to exploitation;
>
> (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
>
> (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.
>
> Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery and forced pregnancy.
>
> Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide and prenatal sex selection.[152]

7.1.2 Prevalence and Forms of Violence Against Women

In the words of Noeleen Heyzer, Executive Director of the United Nations Development Fund for Women (UNIFEM), violence against women "devastates lives, fractures communities and inhibits development in every nation."[153] According to World Bank estimates of the Global Burden of Disease, twenty percent of the total healthy life years lost for women of reproductive age in market-based economies are lost as a result of gender-based violence.[154] Studies conducted in the European Union show that, of the 170 million females in the region, a quarter to a third experience violence at the hands of men.[155] Since the total disease burden is greater in developing countries than in developed, violence

against women is responsible for a much smaller proportion of healthy days lost for women in these regions. In reality, however, the rates of domestic violence and rape are roughly equivalent between developed and developing nations,[156] making violence against women a global epidemic.

Gender-based violence takes many forms and can be perpetrated at any point during the life cycle, from before birth until late adulthood.[157] It stems from the pervasive practice of assigning a lower social status to women and the highly prevalent belief that women belong to men.[158] A number of violent acts against women are described below, along with statistics that illustrate their prevalence.

Abuse by Intimate Partners
This is by far the most common form of violence against women. According to Heise et al., an analysis of 35 studies revealed that from one-third to more than 50 percent of respondents in many countries said they had been physically abused by an intimate partner. The studies incorporated findings from six continents, and showed that an even higher number of women were "subjected to ongoing emotional and psychosocial abuse, a form of violence that many battered women consider worse than physical abuse."[159] Though violence within the home cuts across all demographic groups, a 2003 study in Bolivia suggests that forms of violence worsen as women's age increases and for women without education.[160] In its most extreme form, violence against women can lead to homicide. Statistics from a number of countries show that women are often more likely to be murdered by an intimate partner than a stranger.[161]

Rape and Sexual Assault
According to U.S. studies on rape prevalence, between 14 and 20 percent of U.S. women will be the victims of a "completed rape" in their lifetimes.[162] As for the developing world, research conducted in the late nineties showed that more than 20 percent of African women reported their first intercourse was forced.[163] Around the world, rape has also been used as a weapon of war. In the Balkan conflict an estimated 20,000 to 50,000 women and girls were raped in Bosnia-Herzegovina,[164] and "rape camps" were designed to impregnate enemy women as a form of ethnic cleansing.[165]

Sexual Abuse of Children
According to Heise et al., though the sensitive nature of the sexual abuse of children has limited the number of national studies conducted on the issue, "the few studies that do exist and ample indirect evidence suggest that sexual abuse of children and adolescents is widespread."[166] In research conducted in Zaria, Nigeria, 16 percent of the total number of females treated for sexually transmitted diseases were younger than five, and another 6 percent were between six and fifteen years of age.[167] Global data from rape crisis centers further show that anywhere from 40 to 58 percent of the total number of recorded sexual assaults are committed against girls 15 years of age and under.[168] In some cases the abuse is so widespread that children themselves cite it as the biggest health problem afflicting them, as in Nicaragua where 8 to 15 year old participants of a national conference for children selected physical and sexual abuse as their number one health concern.[169]

Premature Death and Neglect of Girls
In many parts of the world male offspring are preferred over females, sometimes to the extent that selective abortions and infanticide are used to eliminate girls. In China, where the number of births per family has been restricted since 1979, a 1987 census revealed half a million fewer female infants that natural birth patterns would allow.[170] According to the advertising campaign of an Indian clinic

specializing in predicting prenatal sex, it is "better to spend $38 now on terminating a female fetus than $3,800 later on her dowry."[171] A study in Tamil Nadu, India further showed that for females that did make it to full term but died within seven days of birth, 58 percent died from infanticide, generally though poisoning with sap or choking with milk soaked rice hulls. Meanwhile, no male deaths from infanticide were recorded for the same period.[172] Even when girls do live past infancy they often receive less food, education, and medical care than boys. According to Heise et al., in 43 of 45 developing countries surveyed, the mortality rates for females age one to four are higher than their male peers.[173]

Culture-Bound Practices that are Harmful to Women
In their World Bank Discussion Paper, "Violence Against Women: The Hidden Health Burden," Heise et al. expand the United Nations concept of "traditional practices" that are harmful to women to "culture-bound practices." In this way they acknowledge harmful acts against women in industrial countries such as anorexia, bulimia, and plastic surgery that, like traditional practices, are generally perpetuated as a way of conforming to social ideals of beauty.[174]

In many regions, culture-bound practices dictate that girls are married before the age of fifteen, often to considerably older husbands. Surveys show that as many as 26.7 percent of 20 to 24 year old women in both Nigeria and Cameroon were married before age fifteen.[175] These child brides are frequently traumatized by forced sex and childbirth before their bodies have completely developed, which can have serious physical and mental consequences on their health. Furthermore, each year an estimated two million girls undergo female genital mutilation (FGM).[176] A study conducted in Sierra Leone showed that 83 percent of females that had FGM had to seek treatment later in life as a result of the procedure.[177] (The practice of FGM and its impacts will be further addressed in section 7.2.)

Violence Against Women by the State
Far from protecting women, in many countries laws actually serve to legitimize the violence perpetuated against them. Within some systems, men are acquitted of murder if they claim that the act was committed to preserve family honor,[178] rapists who marry their victims are set free,[179] and women face assaults by police, soldiers, and state agents, "the very men charged with their protection."[180] Often, gender-based violence is condoned by the absence of policies and legislation that prevent it.

Though the above categories of violence are by no means exhaustive, they provide a glimpse into the consequences of male dominated societies. In many countries the practice of violence against women is so deeply ingrained in the culture that it is widely accepted and perpetuated by both men and women. For example, women who once suffered at the hands of their mothers-in-law will see nothing wrong with treating their son's bride in the same manner twenty-years later. Similarly, females who underwent female genital mutilation will submit their daughters for the same procedure in the hopes of improving their marriage options. These conditions exact a high cost on the mental and physical health of the world's women.

7.1.3 Health Consequences of Violence against Women

At the international level, the health burden resulting from violence against reproductive age women is roughly equivalent to the burdens associated with HIV, tuberculosis, cancer, and cardiovascular disease.[181] Rape and domestic violence alone are responsible for the loss of 9.5 million disability-

adjusted life years for women age 15 to 44.[182] Studies conducted in the U.S. and New Zealand show that abused women have significantly worse physical and mental health than their non-abused peers,[183] demonstrating that the life years lost from violence are due to both physical and mental disorders.

The physical consequences of violence can take the form of temporary injuries like bruises, cuts and broken bones, or more permanent injuries such as whole or partial loss of hearing or sight, scaring from serious wounds or disfigurement from acts like acid throwing. Violence can also lead to miscarriages, chronic headaches and pelvic pain, repeated vaginal infection, sexually transmitted diseases, permanent disability, and death.[184] Research regarding rape in Bangladesh demonstrates its substantial impact on health, in that 84 percent of victims suffer "severe injuries or unconsciousness, mental illness, or death following the rape."[185]

7.1.4 Mental Health Consequences of Violence Against Women

One unique aspect of violence against women is that its perpetrators are often intimately known.[186] Data indicates that, of all the world's women, between 20 and 33 percent will be physically assaulted by an intimate partner in their lifetimes.[187] Furthermore, a number of studies demonstrate that pregnant women are at greater risk for abuse, and that the violence is more likely to include frequent and severe assault of the abdominal region.[188]

Due to the nature of intimate partner abuse, victims are prone to acute psychological harm.[189] In fact, many women consider the psychological impact of violence to be more devastating than the physical effects.[190] Studies reveal that women who have been the targets of violence have higher rates of "depression and anxiety, stress related syndromes, pain syndromes, phobias, chemical dependency, substance abuse" and suicide.[191] Additional studies show that, even years after they were sexually assaulted, abuse victims are twice as likely to suffer from mental disorders such as "major depression, alcohol abuse, PTSD, drug abuse, obsessive-compulsive disorder, generalized anxiety, eating disorders, multiple personality disorder and borderline personality syndrome."[192] Similarly, 58.6 percent of women who were sexually abused as children, but only 24 percent of their non-abused peers, have at least one psychiatric diagnosis in their lifetimes.[193]

Research also shows that an overwhelming number of women who commit suicide are victims of violence. According Stark and Flitcraft and their research findings on suicide in the United States, "abuse may be the single most important precipitant for female suicide attempts yet identified."[194] Research conducted by Dorothy Counts in Africa, Oceana and South America shows similar findings for the developing world.[195]

The cycle of violence is difficult to break. Regardless of age, race, educational level and substance use, women assaulted in the past are five times as likely to be assaulted in the future than the general female population.[196] One reason for the resiliency of abusive relationships is that women are frequently tied legally, financially, and emotionally to their abusers and find it difficult to severe these connections.[197] Moreover, repeated physical and emotional abuse hinders women's confidence, increases their dependence, and restricts their ability to make independent decisions.

7.1.5 Impacts on Society

Economic

Violence against women is economically detrimental to societies for a number of reasons. Due to its high prevalence and severity, gender-based violence substantially drains health and legal resources. A study conducted in the United States found that "a history of a rape or assault was a stronger predictor of physician visits and outpatient costs than any other variable, including a woman's age or such health risks as smoking."[198] Violence, furthermore, dramatically reduces women's ability to participate in and contribute to economic and social development in their communities and nations.[199] Finally, it contributes to the frequent lack of control women have over reproduction and, hence, leads to the birth of children that families are not economically prepared to raise.[200]

Sexually Transmitted Diseases

Gender-based violence can increase women's likelihood of contracting HIV through forced sex or a partner's refusal to wear a condom. In some societies, even broaching the subject of condom use is considered an insult to a man's masculinity and rights.[201] Women, furthermore, have two to four times the risk of contracting HIV from unprotected sex than men,[202] a fact which further increases the risks of sexual violence for women and society as a whole.

The Wellbeing of Children

Research shows that in households where women are the victims of violence, children are also often abused. For instance in a study conducted in Colombia, 74 percent of battered mothers claimed that their children had witnessed the attack, and 49 percent reported that their children had also been physically abused.[203] Even those children who escape physical harm often develop emotional or behavioral problems such as "depression, aggression, disobedience, nightmares, poor school performance, and somatic health complaints."[204] For society, children's exposure to abuse has a strong consequences since they are likely to continue the cycle as adults.[205]

7.1.6 Interventions

Societal perceptions of and approaches to violence against women take many forms. In nine Latin American countries, rapists are not prosecuted as long as they marry their victims.[206] In some societies, raped women are blamed for bringing dishonor to their families and are ostracized, or sometimes murdered, as a result.[207] At a 2000 gathering of displaced men and women in Kosovo, rape victims were asked by megaphone to come forward. Unwilling to face social stigmas and potential ramifications, women remained quiet and an opportunity for support and retribution was lost.[208] As these approaches suggest, the way that violence against women is handled can have a dramatic impact on women's mental health.

Since gender-based violence is deeply rooted and widely accepted in many societies, interventions cannot focus exclusively on the violence itself but must address the underlying social attitudes and practices that allow violence to be perpetuated. This can be done directly through the mass media, education, or legal and judiciary reforms, or through more indirect measures that confront the mechanisms which keep women dependent on men. After analyzing statistics from 90 societies, David

Levinson determined four factors that, combined, are strong predictors of the prevalence of gender-based violence. The factors include female access to divorce, use of physical violence to resolve conflict, authority and control of decision making in the home and, most importantly, the level of economic inequality between men and women.[209] With this in mind, a possible role for the Bank is in building up the opportunities for women to gain access to training, credit, and resources in order to decrease economic disparities between the sexes.

Cross-cultural studies have also found that predictors of low gender-based violence include female power outside the home, active community intervention, the presence of all-female work or solidarity groups, and access to sanctuary from violence.[210] Supporting economic opportunities for women will help to make power outside the home and all-female work groups possible. Meanwhile, community support systems must be established and should include proper protocols, emergency and trauma unit staff who are trained to provide care and referral support for victims of violence, and systems through which women bringing children to clinics for treatment are automatically screened for abuse. Victims of violence must also be provided with legal and judiciary support, with laws that protect their rights and police that enforce them. In several South American countries, women-only police units have greatly improved the reporting of violence and deterred its spread.[211] According to Heise, even the process of admitting abuse and hearing it denounced by someone else as wrong, "offers relief from isolation and self-blame."[212]

Mental health and psychosocial interventions are essential to the intervention package for survivors of violence against women. Principles of this approach, drawn from a draft manuscript for a book on gender and violence include: *[213]*

- Adapting counseling techniques to local cultures, customs and needs;
- Providing psychological assistance to both women and men, since men can be empowered by-standers;
- Developing a community-based approach;
- Changing attitudes by referring to victims as survivors;
- Providing counseling under conditions determined by the survivor, such as when she is ready to speak, respecting confidentiality, etc.;
- Securing the safety of survivors;
- Making safe places available where survivors can go in an emergency, such as a shelter, or home of a community leader who has offered it for this role (Note: Shelters are not acceptable to all cultures.); and
- Interviewing survivors for the purpose of seeking to provide help, rather than for data collection as part of a study, with no benefit to the survivors.

Some specific psychosocial and mental health interventions include training health care providers so they are able to screen for violence when this may be suspected. This would be in well-baby clinics, gynecological clinics or for any general out-patient visit. Screening instruments have been developed and tested for use. Another approach is to train trauma unit health care workers so they can recognize signs of abuse and provide initial counseling support and referral to support programs. Women who come in with difficult to explain injuries could be screened for abuse and then referred, where it is indicated. In both developing and developed countries, support groups for survivors of violence have been proven extremely effective. They may be groups that meet weekly, drop in centers, or live-in

shelters, but in each case, they provide a respite from the abusive environment, and provide the survivor with psychological support. Such centers may provide alternatives to the abusive situation, such as access to income generating schemes, subsidized housing, welfare payments, legal services, child care, training and other opportunities, that allow the woman to get out of the abusive situation, should she wish to do so.

For more information regarding violence against women, see:

Heise, Lori L., Jacqueline Pitanguy and Adrienne Germain. "Violence Against Women: The Hidden Health Burden." *Discussion Papers* 255, World Bank, July 1994.

7.2 Case Study: Female Genital Mutilation (FGM)

7.2.1 Background

Each year, female genital mutilation is practiced on approximately two million girls around the world.[214] Sometimes referred to as "female circumcision" (FC), or "female genital cutting" (FGC), the practice includes "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons."[215] The procedure is frequently performed without any form of anesthesia.[216] Though FGM is practiced in some areas of the Middle East and Asia and in parts of Europe, Australia, Canada and the United States due to immigration, it is most widespread in Africa.[217] The 1990 Convention on the Rights of the Child condemned FGM, defining it as a form torture.[218]

While there is no basis for FGM in either Islam or Christianity, it is frequently practiced on religious grounds. Other reasons given for its pervasiveness include control of female sexuality, tradition, aesthetic motives, increased hygiene, and myths that it enhances fertility and child survival.[219] FGM takes several forms which the WHO categorizes in the following manner. Eighty percent of FGM cases are classified in the second category, while 15 percent are in category three, the most extreme form.[220]

Type I: Clitoridectomy
Excision of the clitoral hood with or without removal of all or part of the clitoris.

Type II: Excision
Excision of the clitoris together with part of all of the labia minora (the inner vaginal lips).

Type III: Infibulation
Excision of part of all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood.

Type IV: Unclassified
- Pricking, piercing or incision of the clitoris and/ or labia;
- Stretching the clitoris and/ or labia;
- Cauterization by burning of the clitoris and surrounding tissue;
- Scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina;
- Introduction of corrosive substances into the vagina to cause bleeding, or introduction of herbs into the vagina to tighten or narrow the vagina;
- Any other procedure that falls under the definition of female genital mutilation.

7.2.2 Impact on Mental Health

The physical repercussions of FGM have been extensively documented and range from acute pain, urinary tract infections and painful intercourse to complications during childbirth, sterility and possible death.[221] However, though approximately 130 million women and girls worldwide have undergone FGM, in their research the WHO found only one peer reviewed journal article addressing the psychological impact of the practice.[222] The study consisted of interviews with 300 women and 70

men in Somalia, where 90 to 98 percent of the female population has undergone FGM,[223] and the majority of FGM cases are Type III. Bayoudh et al. found that FGM had a variety of psychosexual impacts for women, including a possible link between the divorce rate (25%) and FGM, defibrillation at marriage leading to fear and frigidity regarding sex, and 15 percent of women deriving no sexual enjoyment.[224] Another study, conducted in the Uruan area of Nigeria where Type II FGM is common, indicated that 13 percent of women surveyed attributed "frustration and mental instability" to FGM.[225]

Though there is limited data regarding the relationship between FGM and mental health, it is clear that the practice can have long-term psychological repercussions for women subjected to it, including anxiety, depression, fear, sexual phobias, and feelings of incompleteness. According to Nadid Toubia and her experience as a clinician in Sudan, "thousands of women come to the Ob/Gyn outpatient clinics with vague chronic symptoms which they metaphorically interpret as originating from the pelvis." Though the medical community tends to view the women and their complaints as merely a drain on limited resources, Toubia interprets their physical symptoms as a manifestation of mental distress.[226]

7.2.3 The World Bank's Role

In order to deal with FGM effectively, the social, cultural and economic reasons behind the practice must be understood from the viewpoint of those performing it.[227] With this in mind, the World Bank has approached FGM from a variety of angles. In Guinea, where before 1998, 90 percent of all females were circumcised, the World Bank supported a project providing circumcisers with training in alternative occupations, access to start-up funds for small businesses, and public education regarding the risks associated with FGM. The program was responsible for reducing the incidence of Guinean female circumcisions to 20 percent.[228]

As one of its four funding areas, the World Bank's Population and Reproductive Health Capacity Building Program provides support to organizations working to reduce harmful health practices such as FGM. Thus far, the World Bank has incorporated FGM education in existing social programs in Mali and Senegal.[229] Through its *IK Notes* publication it has also helped to spread information regarding the successful approach of Senegalese communities in their opposition to FGM,[230] and has highlighted the benefits of recent health worker training in lessening FGM's harmful effects and reducing its incidence in Eritrea.[231]

CONCLUSION

More active involvement in mental health issues is critical for reducing the growing global disease burden related to mental disorders. In the World Bank's August 2002 Health, Nutrition and Population Discussion Paper, "Outlining the Scope for Public Sector Involvement in Mental Health," Beeharry et al. applied Paul Musgrove's criteria for public health decision making to mental health to determine the ideal role of governments.[232] The authors found that mental health meets virtually all of Musgrove's criteria for public involvement in health since mental disorders are a large and growing component of the disease burden, cost effective interventions exist for reducing their economic weight, they affect the poor, can cause externalities, and inflict catastrophic costs. Additional criteria, including that private demand for mental health care is inadequate and insurance markets need regulation in order to effectively fulfil mental health requirements, also support the need for government involvement in mental health.[233] Governments around the world are struggling to put programs and systems in place to cope with the rising burden of mental disorders, their impact on personal and social well-being, and their effects on economic productivity. The World Bank has a role to play in facilitating these efforts.

The November 2003 seminar, *Mental Health and the Global Development Agenda: What Role for the World Bank?* provided arguments for why the Bank should become more actively engaged in the area of mental health arena and offered suggestions on its potential contributions. The case studies on conflict and post-conflict, ECD, mental health in primary health care, OVC, HIV/AIDS and violence against women illustrate areas where there is a critical need for intervention, provide descriptions of past approaches, and suggest future courses of action.

NOTES

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[7] WHO, *The World Health Report 2001: Mental Health*, 3.

[8] Ugandan Ministry of Health, *Burden of Disease Study*, 1995.

[9] Harvard Program in Refugee Trauma, <http://www.hprt-cambridge.org/Layer3.asp?page_id=32.>

[10] Information regarding the link between conflict and mental health is courtesy of Florence Baingana and Ian Bannon. For more information see: Florence Baingana and Ian Bannon, "Mental Health," *Social Development Notes: Conflict Prevention and Reconstruction*, no. 13. ed. Sigrun Aasland, Washington: World Bank, October 2003.

[11] Baingana and Bannon, 1.

[12] All statistics are from 2002. The first five statistics are from the World Bank's World Development Indicator Database, while the IMR and Crude Death Rate are courtesy of UNICEF: http://www.unicef.org/infobycountry.

[13] Data related to Palestinian history and the current humanitarian situation is courtesy of the Norwegian Refugee Council's Global IDP Project Database: http://www.db.idpproject.org/Sites/IdpProjectDb/idpSurvey.nsf/ wViewSingleEnv/Palestinian+ TerritoriesProfile+Summary.

[14] World Bank, *Twenty-seven Months- Intifada, Closures and Palestinian Economic Crisis: An Assessment* (Washington: World Bank, May 2003), xi.

[15] World Bank, *Twenty-seven Months*, xi.

[16] Information courtesy of the World Health Organization, 2001, <http://www.emro.who.int/mnh/whd/CountryProfile-PAL.htm.>

[17] Samir Qouta and Eyad El-Sarraj, "Community Mental Health as Practiced by the Gaza Community Mental Health Pprogramme," in *Trauma, War, and Violence: Public Mental Health in Socio-Cultural Context*, ed. Joop de Jong (New York: Kluwer Academic/ Plenum Publishers, 2002), 319-320.

[18] Qouta and El-Sarraj, 320-321.

[19] World Health Organization, http://www.emro.who.int/mnh/whd/CountryProfile-PAL.htm.

[20] World Health Organization, <http://www.emro.who.int/mnh/whd/CountryProfile-PAL.htm.>

[21] MOH-HMIS, *Palestinian Health Care System: Health Status in Palestine* 2002, July 2003, 95, <http://www.moh.gov.ps/annual/2002/mental_health.pdf>

[22] E. El-Sarraj et al., "Experiences of torture and ill treatment and posttraumatic stress disorder symptoms among Palestinian political prisoners," *Journal of Traumatic Stress 9*, no. 3, (1996), 595-606.

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[25] First GCMHP study on the psychosocial effects of Al-Aqsa Intifada, from the website, http://www.gcmhp.net/ File_files/StudyAqsaJuly72k1.html.

[26] Florence Baingana, "Integrating Mental Health into the Primary Health Care System," *West Bank and Gaza Update,* World Bank, April 2002, 7.

[27] Baingana, 6-7.

[28] Baingana, 7.

[29] All statistics are from 2002. The first six statistics are from the World Bank's World Development Indicator Database, while the Crude Death Rate is courtesy of UNICEF: http://www.unicef.org/infobycountry.

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ANNEX A: Seminar Agenda

**Mental Health and the Global Development Agenda:
What Role for the World Bank?**

The World Bank ▪ Washington, DC
1850 I-street, NW ▪ 8th floor, room 300
24th and 25th November, 2003

DAY 1: Monday, 24th November, 2003

8.30-9.00   **Coffee and Registration**
                  Continental Breakfast

9.00-10.00   **Opening Session and General Discussion**
                  <u>Chair:</u> Jacques F. Baudouy, *Sector Director, Health, Nutrition & Population, World Bank*

10.00-10.30 **Coffee**

10.30-12.00 **General Session**
                  <u>Chair:</u> Harvey Whiteford, *Professor of Psychiatry, University of Queensland, Australia and Mental Health Consultant, Human Development Network, World Bank*

- **Theme 1: Mental Health Programming in Low and Middle-income Countries**

- Case Study: Integrating Mental Health into Primary Health Care: Hon. Captain M.G Mukula*, Minister of State for Health, Uganda*

- Case Study: Europe and Central Asia, Profile of Mental Health Investments: Nedim Jaganjac, Consultant, Human Development Unit, ECA Region, World Bank Armin Fidler, *Sector Manager, Health, Nutrition and Population, World Bank*

12.00-12.30 **Question and Answer Session**

12.30-2.00   **Lunch Program** (Brown Bag Presentation)
                  <u>Chair:</u> Oey Astra Meesook, *Sector Director, World Bank*

- **Theme 2: Alcohol and Public Health**

- Presentation on the Public Health and Alcohol Discussion Paper: David Jernigan, *Center on Alcohol Marketing and Youth, Georgetown University*

- Case Study: Russia: Dori Langevin, *Pacific Institute for Research and Evaluation*

2.00-3.00	**Plenary** Chair: Florence Baingana, *Senior Health Specialist (Mental Health), World Bank*

- **Theme 3: Mental Health and Early Child Development**
- Case Study: Oregon Programme: Renee Bradley, *Office of Special Education and Rehabilitative Services, U.S. Department of Education*
- Case Study: Twitezimbere (NGO from Burundi): Pontien Bikebako, *Director of Twitezimbere*

3.00-3.15	**Question and Answer Session**

3.15-3.30	**Coffee**

3.30-5.00	**Roundtable Discussion: Mental Health and the Global Agenda: Partner Perspectives** Chair: Judy Heumann, *Disability Advisor at the World Bank*

- NIMH, WHO, CMHS, Fogarty International, and MDRI

<div align="center">*********</div>

DAY 2: Tuesday 25th November, 2003

8.45-9.00	**Coffee**

- Continental Breakfast

9.00-10.30	**Plenary** Chair: Ian Bannon, *Manager, Conflict Prevention & Reconstruction Team, World Bank*

- **Theme 4: Mental Health and Conflicts**
- Case Study: Bosnia, The Harvard Program on Refugee Trauma Approach: Professor Richard F. Mollica, *Director of Harvard Program in Refugee Trauma*
- The Perspective of the Government: Mr. S. Jovic, *Assistant Minister, Ministry of Health and Social Welfare, Republika Sprska, Bosnia and Herzegovina*, and Mr. G. Cerkez, *Assistant Minister, Ministry of Health, Bosnia and Herzegovina*

10.30-10.45	**Question and Answer Session**

10.45-11.00	**Coffee**

11.00-12.30	**Closing Roundtable Discussion: Mental Health and the Global Agenda: What Role for the World Bank?**

Chair: Jacques F. Baudouy, *Sector Director, Health, Nutrition & Population, World Bank*

ANNEX B: List of Participants

Laurie Ahern
Associate Director
Mental Disability Rights International

Ibrahim Akcayoglu
Operations Officer
Ankara, Turkey
World Bank

Bernard S. Arons
Senior Advisor to the Director
National Institute of Mental Health

Karen Babich
Health Scientist Administrator
National Institute of Mental Health

Florence Baingana
Senior Health Specialist
Mental Health
Health, Nutrition & Population Team
World Bank

Ian Bannon
Manager
Conflict Prevention
& Reconstruction Team
Social Development Department
World Bank

Jacques F. Baudouy
Sector Director
Health, Nutrition & Population Team
World Bank

Pontien Bikebako
Director of Twitezimbere

Renee Bradley
Office of Special Education and Rehabilitative
Services
U.S. Department of Education

Graca Cardoso
National Institute of Mental Health

David A. Chambers
Dissemination and Implementation Research
Program
Division of Services and Intervention Research
National Institute of Mental Health

Pritika Chatterjee
Program Officer
Division for Arab States and Europe
United Nations Population Fund
New York

Christine Comblain
Intern
Health, Nutrition & Population Team
World Bank

Sabine Cornelius
Senior Economist
Regional Human Development
World Bank

J. M. Caldas de Almeida
Chief
Mental Health and Specialized Programs Unit
Pan American Health Organization

Pamela Dudzik
Operations Analyst
Office of the Advisor on Disability and
Development
World Bank

Javier Escobar
Senior Advisor
Office of the Director
National Institute of Mental Health

Signe Flege
Consultant
Health, Nutrition & Population Team
World Bank

Jean-Jacques Frere
Senior Public Health Specialist
Human Development Group
World Bank

Jed Friedman
Young Professional
Development Research Group
World Bank

Mary Gregerson
Chair
Disaster Mental Health Services Committee
for the National Capital Area of the American
Red Cross

Betty Hanan
Senior Operations Officer
Human Development Unit
Europe and Central Asia Region
World Bank

Judith Heumann
Advisor
Disability and Development
World Bank

Mark Homonoff
Inter-American Development Bank

Elliot Hui
Center for Mental Health Services

Nedim Jaganjac
Consultant
Human Development Unit
Europe and Central Asia Region
World Bank

Katja Janovsky
WHO Office at the World Bank and the IMF

David Jernigan
Center on Alcohol Marketing and Youth
Georgetown University

Hadia A. Karam
Operations Officer
Beirut, Lebanon
World Bank

Dale Kaufman
Special Assistant to the Director
Center for Mental Health Services

Gerald Keusch
Director
Fogarty International Center
National Institutes of Health

Fredrick Kigozi
Psychiatrist
Medical Director
Butabika Hospital
Uganda

Lucia Kossarova
Junior Professional Associate
Health, Nutrition & Population Team
World Bank

Dori Langevin
Project Director
Pacific Institute for Research and Evaluation

James Lavelle
Director
International Programs and Community
Organizing
Harvard Program in Refugee Trauma

Michael P. Massagli
Harvard Program in Refugee Trauma

Karla Mcevoy
Operations Analyst
Social Protection Sector
World Bank

Oey Astra Meesook
Sector Director
Regional Human Development
World Bank

Winnie Mitchel
Public Health Analyst
Center for Mental Health Services

Richard F. Mollica
Director
Harvard Program in Refugee Trauma

Daniel M. Mont
Social Protection Specialist
Office of the Advisor on Disability and
Development
World Bank

Masami Morigami
Personal Assistant to the Disability Advisor
World Bank

Hon. Captain M.G Mukula
Minister of State for Health
Uganda

Grayson Norquist
Director
Division of Services and Intervention Research
National Institute of Mental Health

Menahem M. Prywes
Senior Economist
Regional Human Development
World Bank

Juan Ramos
Senior Advisor
National Institute of Mental Health

Eric Rosenthal
Executive Director
Mental Disability Rights International

Agnes Rupp
Chief, Financing & Managed Care
Research Programme
National Institute of Mental Health

Kinnon Scott
Senior Economist
Development Research Group
World Bank

Jovic Stevan
Assistant Minister

Ministry of Health and Social Welfare
Republika Sprska
Bosnia and Herzegovina

John Tuskan
Branch Chief
Center for Mental Health Services

Zane Wilson
Founder
South African Depression and Anxiety Group

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In order to review the past five years of engagement in the area of mental health, the World Bank organized a seminar with partner agencies to bring together practitioners and researchers to share ideas on the successes and challenges of integrating mental health into World Bank activities. The seminar *Mental Health and the Global Development Agenda: What Role for the World Bank?* took place on November 24-25, 2003, at the World Bank Head-quarters in Washington, D.C, and was co-sponsored by the World Bank and the National Institute of Mental Health. This document presents the topics covered at the November 2003 seminar, specifically addressing the future role of the World Bank in the international mental health arena.

The document also explores critical areas related to mental health that must be addressed, and discusses how the Bank can build on what it and its partner organizations have already accomplished in these areas. The specific themes include conflict and post-conflict, early child development, mental health in primary health care, orphans and vulnerable children, HIV/AIDS, and violence against women.

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