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Arjun Srivastava, Head Chair
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Securing access to good mental health in lesser developed and developing nations

World Health Organization (WHO)

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Introduction

Mental health is defined as a state of mental welfare that enables people to manage stress, work well, learn, be in a state of general content and contribute to their community. Mental health is a key component of overall well-being, but access to quality mental health care varies greatly around the world. In poor and developing countries, millions struggle with mental health issues without help due to poverty, stigma, conflict and weak healthcare systems." These include depression, anxiety and trauma many of which are left untreated impacting on education, work and quality of life.

Access to good mental health care is a social and economic as well as a health issue in these areas. Solutions to this problem involve improved awareness, better mental health infrastructure and international co-operation to ensure that mental health care is available, affordable and culturally appropriate for all. "In a lot of low-income countries, there is very little investment in mental health and few trained staff or services, and those that do exist are often only in major cities," (Richard Horton).

In most resource-limited settings, mental health care is under-resourced or non-existent and available service providers are few, not uniformly distributed across cities, and unprepared to manage mental issues. Rural and other underserved communities are left especially vulnerable due to potential long distances of travel for care, or dependence on informal support networks that are unable to provide appropriate treatment. Cultural stigma is another deterrent preventing people from seeking help, and mental health conditions are often misinterpreted as a character flaw or personal failure rather than an illness.

Furthermore, in developing countries such as war-torn, displaced or natural disaster-affected areas have higher incidence of trauma-related disorders and weak healthcare systems cannot easily absorb the burden. Mental health can further entrench cycles of poverty and inequality if people face mental illness without early intervention and long-term support. Increasing access to mental health care thus requires not just increased provision of services, but also the integration of mental health with primary healthcare, education to reduce stigma and community-based responses that can reach those who need it most.

Definition of key terms

Mental Health

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community. It has intrinsic and instrumental value and is a basic human right.

Access to Healthcare

Access to healthcare refers to the ability of individuals to obtain timely, affordable, and appropriate healthcare services when needed. It involves removing barriers that may prevent individuals from seeking and receiving necessary medical care, including physical, financial, cultural, and informational obstacles.

Mental Health Stigma

Prejudices or negative points of view that prevent people from getting mental health help.

Least developed countries

Least developed countries are, according to a classification by international organisations, countries with particularly low levels of economic and human development, there are currently almost 50 in the world

Primary health care

Primary health care is a whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and wellbeing closer to communities.

Mental health care infrastructure

A system of policies, services, and physical and social environments designed to support and sustain a population's mental well-being.

General Overview

The access to good mental health care in various LDCs and developing countries is a challenging aspect of our global world, where economic, social, and structural inequalities are still present. Despite the prevalence of mental health disorders as a component of the global burden of disease, such conditions rarely receive consideration and financial support in most low-income nations. National health plans frequently prioritize more immediate physical health needs, emphasizing infectious diseases, malnutrition and maternal care at the expense of mental health care or without recognizing it. This can result in a lack of trained medical workers like psychologists, psychiatrists and social workers.

The problem is compounded by social and cultural factors. In a number of cultures, mental illness is stigmatised or misunderstood, so people are ashamed to show their symptoms or seek help from unlicensed traditional or religious practitioners rather than medical experts. This can not only be an obstacle to seeking help but also potentially result in discrimination, social exclusion and human rights abuses. Meanwhile the countries usually most affected by conflict, political instability and state failure, natural disaster and forced migration all drive up rates of trauma, and other mental health issues. LDC's healthcare systems cannot act on these issues.

This problem must be tackled from different sides. Governments need to incorporate mental health into national health plans and devote more funds for the recruitment, training, and retention of healthcare professionals; Organization should integrate mental health care into primary health services. Such programs as community-based initiatives, school-based interventions and the use of low-cost digital mental health tools can also be employed to increase access available for underserved populations. International organizations and nongovernmental entities also contribute significantly in the form of funding, expertise and policy direction.

Major parties involved

India

India has one of the largest treatment gaps in mental health, a result of its large population and significant lack of mental health providers. Under the National Mental Health Programme and District Mental Health Programme, it is the government's stated policy to integrate mental health services into primary care and expand services to rural areas, but delivery has been uneven.

Brazil

Brazil has one of the most advanced mental health public systems in the developing world. Community-based care and deinstitutionalization was prioritized through the Psychosocial Care Centers (CAPS), but some regional disparities persist.

Nigeria

Nigeria has poor mental health infrastructure, with almost all services focused in a handful of urban psychiatric hospitals. New reforms highlight the need to mainstream mental health into primary care.

WHO

The WHO provides global leadership on mental health through initiatives such as the *Mental Health Gap Action Programme (mhGAP)*, which helps countries train non-specialist health workers to identify and treat common mental disorders.

World Bank

The World Bank supports mental health by funding health system reforms and linking mental health outcomes to economic development, particularly in low- and middle-income countries affected by poverty or conflict.

Médecins Sans Frontières

MSF provides mental health and psychosocial support in emergencies such as war zones and refugee camps, where trauma and stress-related disorders are common and local services do not exist.

BasicNeeds

BasicNeeds operates at basic level in multiple developing countries (including mental health interventions with livelihood support and social inclusion) to restore individuals to productivity and economic independence.

Timeline of events

1946 – WHO Founded

The World Health Organization (WHO) is founded, establishing global health standards and ultimately campaigning to redefine mental illness as an intrinsic part of all heath.

1978 – Alma-Alta Declaration

The statement reflects primary care as the key to health equity. This principle is subsequently confirmed by incorporating mental health care in local health systems.

1982 – India's National Mental Health Programme (NMHP) started

India starts its NMHP to deliver minimal mental health care through primary health centers with the objective of increasing rural access and reducing treatment gap.

1991 – Brazil implements the Mental Health Service Centers (CAPS)

Brazil initiates community-based mental health programmes in order to decrease the dependence on psychiatric hospitals and provide local care, notably for the urban and semi-urban populations.

2001 – Conceptualization of WHO Mental Health Gap Action Programme (mhGAP)

mhGAP is designed to guide countries with limited numbers of mental health professionals in training non-specialist health workers who can diagnose and treat common mental disorders.

2003 – Nigeria Embarks On Mental Health Integration Initiatives

Nigeria begins pilot efforts to include mental health in primary healthcare, and commences the review of archaic mental health legislation.

2010 – The Growth of Community-Based Ngo's

Groups such as BasicNeeds and Médecins Sans Frontières scale up mental health programs in the developing world, integrating treatment with social support and livelihood initiatives.

2013 – The WHO mhGAP Intervention Guide is Published

Offers protocols for mental health diagnosis and treatment in under-resourced areas.

Relevant UN treaties and events

Universal Declaration of Human Rights (UDHR, 1948) – Article 25: Everyone has the right to a standard of living adequate for health and well-being including medical care as first point for mental health as human rights.

International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) – Article 12 protects the right to the highest attainable standard of health (physical and mental), requiring states to make health services available for everyone.

WHO/UN Joint Committee on Mental Health Promotion and mental health mental care (1983) Alma-Ata Declaration (1978, WHO/UN) - The declaration advocates for primary healthcare being the means to attain "Health for All" – inclusive of the integration of mental health specifically within rural and underserved populations.

Convention on the Rights of Persons with Disabilities (CRPD, 2006) – Focuses on the rights of individuals with mental and psychosocial disabilities to: have access to healthcare live independently participate fully

World Health Assembly Resolutions on Mental Health – In 2001, 2013 and 2017 resolutions member states are called upon to develop national mental health policies, financial resourcing and inclusiveness in primary care with an emphasis on low-resources and conflict-affected settings.

UN Sustainable Development Goals (SDGs, 2015)—Goal 3 ("Good Health and well-being"), as one of the SDGs explicitly mentions mental health and well-being: to achieve "universal health coverage, access to quality essential healthcare services" for all, including vulnerable groups by 2030.

High-Level Meetings on UHC (2019) -The UN meetings stress that for UHC commitments, mental health should be made a part of it with reference to equity in LMICs and the integration of mental health into community health programmes.

Previous attempts to solve the issue

India – National Mental Health Programme (NMHP, 1982)

NMHP was initiated in India to streamline mental healthcare into primary health systems and reduce treatment gaps in rural India using the District mental health programme. Nonetheless, severe shortage of funds, professionals and uneven implementation continues to hinder the programme.

Nigeria – Integration into Primary Care (2003 onward)

Nigeria began pilot projects to decentralise mental health services, amend antiquated legislation and subsequently train primary care staff to manage mental health at the primary care level. Access in rural areas has been hampered by stigma, lack of awareness, funding and mental health professionals.

Brazil – Psychosocial Care Centers (CAPS, 1991 onward)

With the establishment of CAPS in Brazil, community based care and rehabilitation became a social inclusion reality, and a rehabilitative alternative to psychiatric hospitals. Despite rural community CAPS being a reality, community based rehabilitation remains elusive in many rural areas.

WHO - Mental Health Gap Action Programme (mhGAP, 2001)

mhGAP is a programme designed to improve the capacity of non-specialized healthcare workers in the identification and management of health care related mental disorders in resource poor settings. Its implementation in developing countries has been successful in addressing local healthcare gaps, but there are resource and integration gaps at the ngational level.

Médecins Sans Frontières (MSF)

MSF integrates mental health and psychosocial support with community outreach and clinical care in disaster zones, conflict regions, and refugee sites. While the approach is good for emergencies, the dependence on temporary staff and funding is an unsustainable practice for the future.

Digital and Telemedicine Initiatives (2010s–2020s)

In India, Kenya, and Nigeria, telepsychiatry, mobile applications, and online counseling facilitate remote access. They offer support for prompt interventions and eliminate the need for travel, but these services still rely on digital literacy and connectivity, and the lack of funds still compromises the sustainability of the system.

Possible solutions

Incorporating mental health services into primary healthcare may be the best way to increase mental healthcare access in developing countries. Preparing general practitioners, nurses, and community healthcare workers to identify and address basic mental health problems can help bring care closer to patients. This can minimize the reliance on mental health hospitals, which in many instances, are only available in large cities. Integrating mental health care with primary health care is a strategy to help address mental health problems in patients and 'normalize' mental health care within the existing health care systems.

Community mental health programs are another feasible option. Utilizing Brazil's CAPS model, community mental health programs can provide local, outpatient, integrated rehabilitation and psychosocial support services. This can help community members with mental health problems remain socially included and connected to their communities. Community mental health programs can also help relieve the stigma associated with mental health challenges through education, awareness, and the active involvement of local leaders, caregivers, and families in the support process. Bringing mental health care to the community, beyond the traditional health centers, is especially relevant in rural and hard to reach areas.

Dgital solutions combined with task-sharing approaches create further opportunities for access expansion. Telehealth, online therapy, and mobile mental health applications may serve regions with poor health system infrastructure. At the same time, programs like the WHO's mhGAP train teachers, community leaders, and lay health workers, so that more individuals can recognize, assist, and make referrals for the mentally ill. The digital tools and local staff may improve reach, minimize treatment waiting time, and offer preemptive interventions to avoid deterioration of the ill.

Lastly, these efforts require international cooperation, funding, and policy change. More mental health preventive and promotional activities should be financed; the policies providing social protection for the mentally ill should be reformed; and budgets should be made for mental health activities for the long-term. The World Health Organization, the World Bank, Médecins sans Frontières, and BasicNeeds should be assimilated for sponsorship, know-how, and educational assistance. Community-based, workplace, and school-stigma alleviation activities can be incorporated to promote help-seeking. Together, these activities should develop a system where mental health assistance is available, acceptable, and affordable to everyone.