Mental Health Systems in Refugee-Producing Countries

The Access to Care, Institutions, and Culture of Mental Health

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Access to mental health care is an uphill battle in many developing countries. The conditions that produce refugees, including civil strife and political oppression and persecution, are often indicators of governments and systems that are unwilling or unable to support its population's health needs. Mental health concerns, including PTSD, schizophrenia, and depression, all of which can be related to or exacerbated by poor and dangerous living conditions, are often the last health needs treated due to their internal nature; physical care for endemic and epidemic illnesses are normally prioritized. Due to the widespread difficulties of access to mental health care in the developing world, it is unlikely that a government's failure to address its population's mental illness could serve as grounds for said individuals to claim and receive refuge in Canada, particularly in a climate of exclusionary Canadian migration policies. These reports can nonetheless be used to contextualize a refugee claimants' experience, provide background for social workers and health professionals managing their cases, and help paint the picture of the troubled conditions from which claimants are fleeing.

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AFRICA

Eritrea

Eritrea's low GDP and small population contribute to the country's trouble creating a strong enough platform to address the population's needs. The country gained self-determination from Ethiopia in 1993, and has made improvements regarding mental health since, but the priority of its health budget has been physical care and not creating mental health institutions. The country now allocates a reasonable 5% of its mental health budget to mental health, but 93% of that amount goes to the country's one mental hospital.[i]

Access & Human Resources

Eritrea has very limited human resources to deploy in its mental health system. The number of total human resources is 0.83 per 100,000, including 0.06 psychiatrists (2 total nationwide), 0.06 other medical doctors (2 practicing non-psychiatrist physicians), and 0.03 psychologists (1 psychologist nationwide). The Journal of Eritrean Medical Association cited this human resource shortage as the greatest bottleneck to improved care, and that for each one psychiatrist in the developing world there are 180 in the developed world.[ii] All four of the psychiatrists and other doctors work in the public mental hospital. The country has one mental hospital, primarily staffed by a variety of nurses and health assistants holding the other 47 jobs.[iii]

There are neither any mental hospitals, nor any psychiatrists, nor any psychiatric nurses practicing outside of the capitol city.[iv]

Eritrea has made an effort to increase training, but the accelerated training could be detrimental in the long run. The Ministry of Health has begun to train 60 primary care workers in basic mental health knowledge, giving one week courses to nurses and physicians to train them to diagnose the most common mental disorders. However, the Ministry offers no follow-up supervision, making it difficult for the workers to have their diagnoses reviewed. There is also little ability for these new staff members to prescribe mental health drugs because of the country's weak psychotropic drug distribution capacity.[v] Additional training has been put in place to train more psychiatric nurses for roles in community mental health. However, the poor access to psychotropic drugs may stifle new efforts to decentralize the mental health system.

The poor availability of psychotropic drugs has rendered their free access moot. The combination of poor drug access, limited facilities, and cultural factors lead only 3% of those with mental illness to receive care. This 97% treatment gap is well above the global average range of 76%-85%.[vi]

Culture

The somewhat archaic management and organization of mental hospitals is worrisome for human rights. There is one residential facility in Eritrea's capital city of Asmara for 150 chronic patients. It is operated by the local government and not integrated with the Ministry of Health, and is primarily run by health assistants. The lack of specialized professionals present at this facility could make it susceptible to human rights abuses or a failure of monitoring. This system is particularly troubling because of Eritrea's poor national human rights record, particularly its repressive government and disinterest in allowing access to outside countries.[vii]

There is no human rights review in mental health facilities and no emergency preparedness plan. 36% of admissions to mental hospitals are involuntary, and 33% of patients in mental hospitals are physically restrained at any point in time. 22% of patients spend five or more years in the hospital; it is unclear to what extent, if any, their cases are regularly reviewed.[viii]

Those with mental illness are often directed towards prayer and spending time with family. Traditional healers are also consulted when mental health problems arise.[ix]

There is a coordinating body for public education, and both government agencies and NGOs have hosted awareness campaigns. These campaigns have not chosen to collaborate with other groups, such as primary or adolescent health, within the Ministry of Health. The government has created legislative provisions regarding the mentally ill. Provisions for equal employment are not enforced, but provisions for access to state subsidize housing are enforced.[x]

Ethiopia

Ethiopia has made legislative strides to improve its mental health access and awareness, but has failed to demonstrate the political will to live up to those standards. The WHO is concerned with a "lack of awareness of the importance of mental health in [Ethiopia's] overall development."[xi] 15% of the country suffers from a mental illness. Ethiopia spends 3.4% of its GDP on public health, with 1.7% of that going to mental health. Currently, 77% of Ethiopians have access to general public health, and 50% of children are fully immunized.[xii]

Access

65% of those who attend mental health service have free access to the essential psychotropic medications. For those paying out of pocket, the cost of antipsychotic medication is 3% of the daily minimum wage, while antidepressants are 6% of daily minimum wage. There are no social insurance plans that cover health.[xiii] These drugs can be prescribed by all primary care physicians, and primary care nurses have some ability to prescribe, with restrictions.[xiv] Psychotropic drugs are not always available: between 50%-80% of primary care physicians have consistent access to drugs from each of the five main categories (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).[xv]

Long term facilities are also not always accessible, with only one mental hospital and one residential facility for the mentally ill. Ethiopia has found success creating an equitable system, though, with mental health services equally accessible to members of linguistic, ethnic, and religious minorities.

In 2006, Ethiopia made plans to create a National Mental Health Institute to open in 2009. Little has been reported since 2009, when the institute was in an early phase. Of note are the goals of the institute, which highlight the direction Ethiopia is hoping to take its health plan. This includes:

- Overseeing training, service planning, and monitoring
- Reform the Federal Ministry of Health to create a state-owned pharmaceutical fund, increasing access to psychotropic drugs at public health facilities
- Continue mainstreaming of mental health care (initiated in 2005)[xvi]

The proposal also hopes to address a shortage of human resources through foreign collaboration and a shortage of medication through more consistent funding agreements with regional health bureaus.[xvii]

Health Professionals & Rural Care

There is a lack of human resources in the mental health field. This begins with university training: only 2% of doctor training and 3% of nurse training addresses mental health. There are only 0.02 psychiatrists and 0.3 psychiatric nurses per 100,000 Ethiopians, with a dangerously low 1.2 total mental health workers per 100,000.

The lack of staff is exacerbated by the urban-rural divide of mental health care. All eleven of the psychiatrists work in the capital city of Addis Ababa.[xviii] Also, the density of nurses per capita is eight times greater in the capital city than elsewhere, and all of the mental hospital beds are located in or near the capital. However, 82% of the country lives in rural areas, predominantly working as farmers.

Culture

There is no legislation to protect the mentally ill against work discrimination, but recent law allows for a psychiatrist's testimony to reverse an employer's actions of discrimination in the workplace. There is also no housing provision for homeless who are mentally ill.[xix] The ministry of health is the only body that reviews mental hospital, a concern for those who want an external human rights review of facilities. One strength of the human rights system in Ethiopia is that all mental health staff, 30% of community-based outpatient staff, and 16% of community in-patient staff have received at least a one-day workshop on human rights. This is stronger human rights training than in countries with systems comparable to Ethiopia.[xx]

Ethiopia has seen increased promotion of mental health public education and awareness since 2000. Government agencies, including mental hospitals, the Department of Health Education, and mass media have promoted mental health, with outside support from private newspapers and magazines.

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Nigeria

Nigeria's mental health system is a primarily government-run, urban-based system plagued by a lack of specialized medical professionals and culture of stigma and myth surrounding mental health. The prevalence of mental illness in the general public stands between 20% - 28%. Nigeria allocates 3.3% of its health budget towards mental health, falling below the WHO recommendation of 5% minimum allocation and global tendency to allocate up to 15%.[xxi]

Policy

Nigeria created a mental health policy in 1991 that outlined primary goals for the country. That list included plans to do the following:

- Integrate mental health into general health
- Decreasing stigma, focusing on positive attitudes in general public
- Ensure equal rights to treatment for those with mental illness as those with physical illness
- Emphasize access to care for minority groups[xxii]

This policy has struggled to be implemented in part because there is no government position specifically in charge of mental health. Rather, the duties regarding mental health are overseen by ministry officials with other primary positions.[xxiii] As of April 2012 a draft of a Mental Health Bill has been submitted to the National Assembly, but has not yet been passed into law.[xxiv] It is unclear at this time exactly how that bill would help implement previously legislated policy.

Access

33% of the Nigerian population has free access to health care. The national health insurance plan was intended to provide short-term coverage for those with mental disorders, but that has not been the case in practice. As of the WHO's report in 2006, most people with short-term meeds were paying out of pocket. [xxv] There is strong availability of all drugs at the outpatient facilities, with at least one drug of each primary class available year-round (rural access is more difficult: See Below.) The cost of antipsychotics is 7% of the daily minimum wage, and the cost of antidepressants is 5% of the daily minimum wage. The availability of drugs

is limited over time, though, as there is a maximum duration of treatment set at 21 days for many cases.[xxvi]

There are also concerns that access is impeded by the strong government presence in the mental health system, although scholars do not overtly address this. All seven mental health facilities are government-owned, and 95% of the psychiatrists in the country work exclusively for government health facilities.[xxvii] This leaves very little financial and human resources for other facilities; for instance, only 5% of psychiatrists work for the NGOs, for-profits, and unaffiliated mental health clinics in the country. There are also zero mental health professionals posted in primary or secondary schools[xxviii]

There is a very limited pool of highly trained and concentrated human resources in the country. There are 11.37 mental health workers per 100,000 members of the general population. The majority (8.03 of 11.37) fall under the category of "other mental workers." There are a mere 0.15 psychiatrists and 0.07 psychologists per 100,000 Nigerians. The ratio of Nigerians falls well below the WHO's minimum recommendation of a minimum 0.4 psychiatrists per 100,000. These low numbers are in part due to the migration of psychiatrists: 25% of psychiatrists leave Nigeria within five years of completing training.[xxix] [xxx].

Rural vs. Urban

Access and awareness of mental illness is rare in rural regions. The density of beds in mental hospitals is highest in Lagos, the most populated city in Nigeria, and all of the countries eight mental hospitals lay in cities. For those living rural regions to pursue care, many would have to leave their state to reach the closest mental hospital.[xxxi] Many in rural areas have trouble even getting a diagnosis, though, because primary health care in rural areas normally excludes mental health services. Early, accurate identification of mental illness is rural areas is rare.[xxxii]

Culture

70% of Nigerians with mental illness seek care through non-orthodox means of healing, primarily religious groups or traditional healers.[xxxiii] Traditional beliefs of illness and healing are still predominant in Nigeria. The common belief is that witchcraft, voodoo, and ancestry cause schizophrenia, and only wizards, voodoo priests, and other ancestors can heal the illness.[xxxiv]

Other mental illnesses are attributed to "wrong" lifestyles, including smoking marijuana. These beliefs are prevalent across society, with many members of the highly educated classes believing in traditional medicine as well.[xxxv]

Mental illness is addressed by witch doctors through means including confinement, exorcism, flogging, chaining, and giving concoctions that sedate violent patients.[xxxvi] The treatments provided by psychiatrists are looked down upon, as well as the professionals themselves. Many psychiatrists are shunned or avoided because of the fear that mental illness is communicable, and that psychiatrists will pass on mental illness to their children. This fear of communicability also leads many family members to avoid placing family members in the care of mental hospitals, to avoid them being surrounded by other "mentally derailed persons."[xxxvii]

Hospitals have trouble maintaining standards of those who are admitted to their care. Human rights laws were set in place in 1995, but no monitoring activities for mental hospitals or community facilities were set in place. 64% of all mental hospital admissions are involuntary, meaning they are initiated by families and resisted by patients.[xxxviii] Only 14% of all mental health staff has received any human rights training. Officers do conduct visits to prisons, though, to ensure conditions there.

Education and awareness is an uphill battle. There is a notable negative depiction of the mentally ill in media coverage.[xxxix] While groups in and outside of the government have made efforts at times to educate the public, there is no government or independent body overseeing education campaigns and no structure for inter-agency cooperation.[xl] There is some expectation that psychiatric nurses would work in this field, but their full workload prevents them from contributing strongly to building awareness.[xli]

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Sudan

Health has been named Sudan's national primary concern, but the country's investment is almost entirely in physical care. The lack of human and financial resources to address epidemic diseases has made consistent mental health care difficult to find and afford in non-emergency situations. There have been calls for prioritization of mental health care in the new country of South Sudan, with the hope that psycho-social care can help foster development.[xlii] It is yet unclear if those changes will be made in the new state.

Access

Sudan has strong legal access to mental health medicines, but there are many situations in which rightfully obtaining drugs is costly and difficult. Every citizen has free access to essential psychotropic medicines, but only in situations deemed psychiatric emergencies. Otherwise, they must pay out of pocket. Out of pocket expenses are relatively very high, with antipsychotic drugs costing 27% of the daily minimum wage and antidepressants costing 18% of the daily minimum wage[xliii]. This would likely be considered unaffordable by many Sudanese. For those who do have a psychiatric emergency, though, drugs can be readily accessed in outpatient facilities, with all facilities having at least one form of each psychotropic drug.

There are 0.92 mental health workers per 100,000 Sudanese, with 0.06 psychiatrists and 0.09 non-psychiatric doctors. These numbers do not seem likely to increase in the immediate future, as very few students are graduating from medical schools with a specialization in mental health. 50% of the workers are practice in the government-run care, 21% in private care, and 29% in both. This is a more evenly balanced distribution than in comparable countries. The private practices, though, are largely unregulated, especially the work of psychologists.[xliv]

The form of care is heavily skewed towards inpatient care. There are neither systems in place that promote follow-up treatment nor mobile mental health facilities.

Rural Care

Drugs are most easily accessed in or near the capital city of Khartoum, and both the mental health hospitals are located in Khartoum. 80% of psychiatrists are located there, despite only 18% of the population living in Khartoum.[xlv]

Culture

Human rights are of concern, as there are no systems in place to monitor or report violations. There is no national human rights review body, and any review of protection is inconsistent. Also, the mental health staff members working in mental hospitals are untrained in human rights practices.[xlvi]

There is no legislative support for those with mental illnesses. Mental health groups also have weak or nonexistent connections with other social services, making it difficult for mental health workers to help their patients navigate the fields of employment, housing, and welfare.[xlvii] There is also no body that oversees awareness or education efforts surrounding mental health.

Those who do have a mental illness are oftentimes neglected and abandoned, in part because of the cultural belief that their mental illness is a result of witchcraft. Some end up in prison and are mistreated, for fear that they are dangerous. One prisoners' rights advocate says they are "treated like wild animals." From a group of 60 individuals he believes are imprisoned for their mental illnesses, the advocate is particularly worried about 13 who have been imprisoned for over twenty years and whose health have steadily dwindled.

ASIA & SUB-CONTINENT

Myanmar

Only 0.3% of the health budget is spent on mental health. 87% of this amount goes towards mental hospitals. The taxing struggle to access care could be increasing mental illness, as well. Insufficient financial allocation and a poor pool of human resources are the major restraints on better care for a country that has relatively affordable drugs and decent awareness and monitoring systems.

Access

Myanmar has a dangerously low 0.477 human resources per 100,000 general population, half of which are nurses. Myanmar has 0.16 psychiatrists per 100,000. The country has 89 total psychiatrists; the World Health Organization would recommend a minimum 356 psychiatrists for Myanmar's population. This does not seem likely to improve soon, as only 4 psychiatrists graduated from Myanmar universities in 2006, and as many as 20% of psychiatrists emigrate away within five years of receiving their degree.[xlviii] The country also only has four total psychologists and one occupational therapist.[xlix]

Access to drugs is strong, with at least one of each kind of psychotropic drug available in inpatient facilities, outpatient facilities, and mental hospitals. 31% of the population has free access to mental health care, when free psychotropic drugs are available from the hospital. For those paying out of pocket, antipsychotic medications cost 6% of daily minimum wage, and antidepressants cost 9% of daily minimum wage.

There is extremely low outpatient care for adolescents, who make up less than one percent of all outpatient users. There are also no mental health professionals working at any primary or secondary schools in the country. The care at the one day facility specifically for youth is far more tailored to mental retardation and disability than mental illness. Only 30% of these patients are female, suggesting a gender inequality of youth mental health care access.[l] Adult females seem to also struggle with equal access; only 20% of patients at the country's two mental hospitals are female.

Rural Care

70% of the population lives in rural areas. There are 1500 rural health centers, but very little psychiatric care in rural regions. The density of psychiatric beds per population is over ten times greater in cities than rural regions, and the density of psychiatrists is over four times greater in cities than rural regions.[li]

Culture

There is a monitor and research board which annually collects and publishes data collected from across the country. This information is community based, increasing the representation of the data, and is collected using a data dictionary to ensure standardized terminology and clear definitions of illnesses.[lii]

There have been public education campaigns delivered collectively by traditional, conventional, and modern medicine providers. It is unclear if these campaigns are consistent, and if they ever target the general public or only focus on targeting professional groups and health care providers.

Traditional medicine is still actively practiced in Myanmar. There is a University of Traditional Medicine, and the country's comprehensive health plan can be applied to traditional medicine.[liii] 85% of the country uses traditional medicines, either as a supplement to Western medicine or as an alternative. This is in part because traditional medicine is ten to twenty times cheaper than Western medicine. Traditional medicine is also readily accessible, with over 10,000 traditional medicine practitioners across the country.[liv]

A human rights body exists, and has the capacity to oversee general facility inspections, involuntary admissions reviews, complaints, and discharge procedures.

Pakistan

Pakistan's human resources and facilities outpace similar low and middle income countries, but a lack of funding and failure to guarantee equity for those with mental illnesses has prevented Pakistan's mental health system from joining the ranks of higher income countries.

Policy

Pakistan's mental health policy was revised in 2003, and included development of community mental health services, downsizing mental hospitals, great advocacy and equity, human rights protection, and a new approach to financing mental health needs. The country also enacted an emergency preparedness plan in 2006. Despite these broad goals, only 0.4% of the government's health care expenditures were allotted to mental health.[lv] This is surprisingly low, especially considering the high contact rates and human resources available. This low allotment is likely affected by the poor general health structure, and the pressing need for more public hospitals and services outside of major cities.[lvi]

Access

Only 5% of the population has free access to essential mental health drugs. Drugs are relatively affordable, with antipsychotics costing 3% of the daily minimum wage and antidepressants costing 7%.

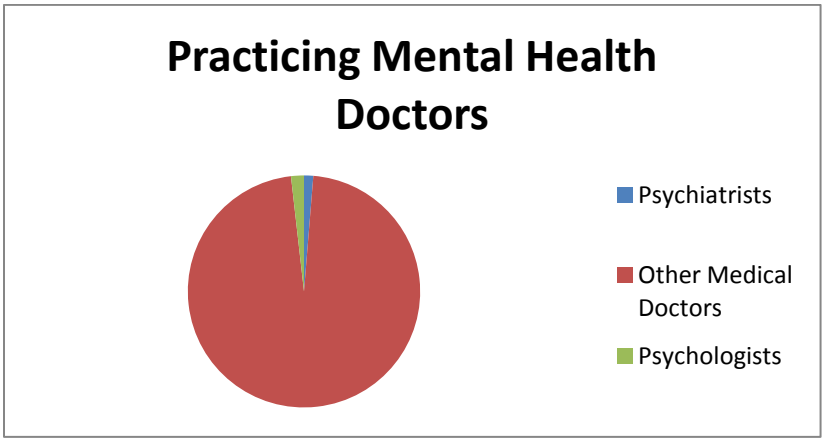
Pakistan's facilities effectively make and maintain contact. The 3729 outpatient mental health facilities in the country treat 343 users per 100,000 general population, and the average number of contacts per user is 9.31. A strong follow-up care system in the community is utilized by 46% of patients. The outpatient facilities are also organizationally integrated with mental hospitals, allowing patients to easily access the care most appropriate for them.[lvii]

Human Resources

Pakistan's human resources have been well-trained in mental health, with an exceptional 27% of training for medical doctors devoted to mental health.[lviii] The burden for mental health care in Pakistan is placed strongly on doctors; only 3% of nurses' training is devoted to mental health. This differs from many countries with lower GDP per capita, in which doctors' work is

far more focused on physical care and endemic diseases, and nurses have a higher percentage of their training devoted to mental health.

There are 87 human resources working in mental health per 100,000 general population. This is very strong. Of note is that there are 75 times more non-psychiatrist doctors than psychiatrists practicing in the field of mental health (0.2 psychiatrists per 100,000 vs. 15.37 other doctors). This is explained in part my college graduation rates: 2.1 medical doctors graduated per 100,000 population in 2008, compared to only 0.002 psychiatrists. Those who do go to school for psychiatry are often offered higher salaries from Western states and choose to emigrate.[lix] The medical doctors who practice psychiatry have been well-trained due to the Pakistani schools' emphasis on mental health, but it would be preferable for a significantly higher percentage of the practicing doctors to be psychiatrists. Psychiatrists are very well distributed across sectors, with 45% working in government facilities, 51% in NGOs or for-profits, and 4% in both.



Rural Care

68% of the population is rural. Pakistan's psychiatrists, like many comparable countries, are concentrated in urban areas. The density of psychiatrists in the largest city is 2.29 times greater than the countrywide density.

Culture

Public education campaigns have been led by the Ministry of Health, NGOs, professional services, and private trusts, and are overseen by a coordinating body. They have most often

targeted vulnerable populations, including children, women, trauma survivors, and ethnic groups. There is legislation that similarly supports that with mental illness, including provisions to hire disabled people, provisions to ensure fair access to housing, protection from job dismissal on account of mental illness. This legislation, however, is rarely enforced.[lx] Inequity of access for linguistic, ethnic, and religious minorities is a moderate issue.[lxi] There are also many anecdotal stories of stigma and the shame felt by families of those with mental illness, such as this schizophrenic painter. It is still common to believe that mental illness is the result of "a curse, a spell, or a test from God."[lxii] Thus, those afflicted often turn to religious healers rather than mental health professionals for support.

A monitoring system is in place, and all mental health facilities submit information to it. This allows for a range of research on topics such as mental illnesses present in the country and the success rate of different forms of personal and medical intervention.[lxiii] The quality of research coming out of Pakistan has been criticized by academics, saying that the papers are produced for promotions and do not achieve a high standard.[lxiv]

LATIN AMERICA

Regional Overview and Mexico

Regional Structures

The majority of Latin American countries allocate less than 2% of their annual budgets for health care expenditures. Scholars believes this low expenditure rate "[compounds] a dismal picture already affected by everyday stresses" such as massive migration flows and domestic violence. The budget of Latin American countries is affected by cultural components. There is shame and guilt associated with mental illness in the region. Many people afflicted with mental health illnesses use unorthodox help-seeking practices. Also, those making the budget prioritize long term health projects to improve primary care in the region. These factors stunt the growth of Western mental health systems, and lead to wide unavailability of appropriate mental health services. The general disregard for mental health care affects the living conditions of those with mental illness: there are problems in the region of human rights violations against patients and their families, negligent care in mental health facilities, and poor housing conditions of the mentally ill. [lxv]

As of 2005, 75% of Latin American countries now have mental health legislation. One of the major regional goals is to incorporate this into primary health care. 90% of countries claim that they have done this, but scholars consider mental health to be insufficiently integrated in most Latin American countries.[lxvi]

Regional Access

The regional estimates suggest that 18-25% of Latin Americans have mental disorders. However, only 1 in 5 patients in need of mental health care receive it. Regionally, there are 1.6 psychiatrists, 2.7 psychiatric nurses, 2.8 psychologists, and 1.9 social workers per every 100,000 people. There are 3.3 psychiatric beds per 10,000 individuals. 48% of those come in psychiatric hospitals, 17% in general hospitals, and 36% in other community settings.

Mental health professionals are among the lowest paid medical professionals in most Latin American countries. Training for mental health professionals occurs in facilities with limited

staff and equipment, and little monitoring from government agencies. There has recently been a slight increase in trainees, but also consistent emigration of professionals.

The concentration of professionals is in metropolitan areas, leaving the 45% of the region that lives in rural regions less attended. The process of visitation for those with mental health concerns goes as follows: they are first seen by non-professionals, the non-psychiatric professionals, then mental health professionals. This lengthy and likely expensive process is forgone by many, particularly since insurance coverage for mental illness is minimal in the region.[lxvii]

Mexico

Mexico has the strongest social security sector in Latin America, but this has not defrayed the high cost of mental health care that deters many patients, especially youth. Social security is available to 70.4% of Mexicans.[lxviii]

In a study of access to care for Mexico City youth, though, less than 1 in 7 youth with any psychiatric disorder had received cared in the last year. This was a lower percentage than adults, partially because so few personnel specialize in adolescent mental health care. The percent of these adolescents receiving minimally adequate care ranged from 27-58%, based on the operational definition of "minimally adequate." This was based on a combination of low resources, stigmatization, and patients rejecting some prescriptions. Also, for anyone paying out of pocket, the prices would be very high. Young females were treated at a higher rate; one hypothesis is that the culture stresses a tradition of protecting young women more so than young men. Also, 40% of the population that did use the services available to urban youth had no disorder, a misuse of the already scare resources.[lxix]

New efforts to promote mental health have been made. NGOs recently have introduced educational activities to build understanding of mental illnesses. Mexico also has the benefit of additional research to support awareness efforts, with the only functioning institute of mental health research in Latin America.

Honduras

Honduras has an interest in addressing mental health, but not the resources to do so. Only 1.75% of the annual health budget goes to mental health, well below the WHO's recommendation of a minimum 5% mental health allotment, and not nearly enough to implement the broad policy changes that have been devised.[lxx]

Access

Honduras' policy decisions over the last two decades have demonstrated a steady interest in improving mental health care. The country began a postgraduate psychiatry training program in 1994, demonstrating an investment in increasing human resources. Honduras later created a policy working document to develop "National Mental Health Policy 2004-2021," with primary goals of promoting community health, decentralizing mental care, and incorporating mental health into the general health system. This whole program has been cultivated by the Health Secretariat's mental health program, instituted in 1975, which has been a consistent promoter of the mental health system.[lxxi] Perhaps most importantly, prominent government institutions have demonstrated the political will to continue to introduce and implement new strategies.[lxxii]

Unfortunately, insufficient funding has made it difficult, despite strong policy, for the mental health system to address the needs of its citizens. There is both a lack of resources and a poor distribution of the resources available. Human and financial resources are heavily skewed towards mental hospitals, with 88% of the mental health budget going towards them.[lxxiii] This creates a great disadvantage for primary care and community mental health facilities.

The juxtaposition of policy and practice is most clearly seen in access to psychotropic drugs: 100% of the country's population is supposed to have free access to mental health drugs while in mental hospitals, but the supply of drugs is very limited. It is also very difficult for primary care physicians to get any access to psychotropic drugs.[lxxiv] Social security systems are intended to cover costs of mental health medicine, but the system has lacked the resources recently, forcing users to pay entirely out of pocket. This is extremely pricey, with antipsychotics costing 26% of the daily minimum wage and antidepressants costing 19% of the daily minimum wage.

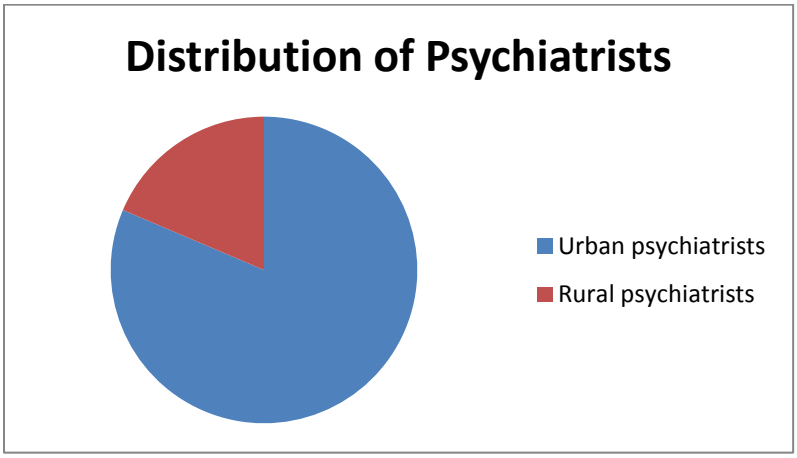
Human Resources

Mental health is a relatively well-taught health sub-sector, with 5% of all training for medical doctors devoted to mental health, and 7% of all nurse training. These professionals rarely get refresher courses after their degrees, with only 4% of primary care doctors and 2% of nurses have received continued training. Refresher training is difficult to access because it is only offered in one region of the country.[lxxv]

The number of human resources in the mental health system is a reasonably strong 6.12 per 100,000. This includes 0.81 psychiatrists, 0.67 other medical doctors, and 2.58 nurses. Psychiatrists are reasonably well divided between facilities, with 21 psychiatrists in outpatient facilities and 27 in mental hospitals. [lxxvi]

Rural Care

While Honduras has hopes of decentralizing mental health care, it has not happened yet. Mental health professionals are still concentrated in the capital city, despite 45% of the population living in rural regions.[lxxvii] 35 of 43 psychiatrists and 156 of 186 mental health nurses practicing in Honduras were located in cities.[lxxviii] Rural users are often most in need of services, but least able to access them. The rural populations in extreme poverty often do not seek mental health care until their symptoms are so severe that they require hospitalization.



Culture

Honduras lacks a human rights review body. There is also no internal review at mental health hospitals, and mental health workers do not receive any training of human rights protection. There is also no record of involuntary admission or restraining of patients, and no practice of recording human rights conditions of patients.[lxxix]

Inequity of care is a major issue in the country. The most disadvantaged linguistic and ethnic minorities struggle to get equal access to care. This problem is particularly worrisome because of the country's high multiculturalism, with eighteen distinct ethnic groups. There are also no legislative provisions for those with mental illness, which can contribute to housing and labor discrimination.[lxxx]

The role of advocacy is primarily taken by NGOs, who focus particularly on promotion and rehabilitation for women and children.[lxxxi]

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MIDDLE EAST

Afghanistan

Afghanistan has an abysmally poor mental health system, with entirely inadequate funding, human resources, and urban-rural balance to care, among other problems. The only upside is the policy proposals that would increase training and education; these projects, though, are strongly reliant on outside donorship to become a reality.

Access

In a 2004 national survey, 68% of Afghanis had some form of depression, 72% had anxiety, and 42% had PTSD.[lxxxii]

The level of access does not meet the level of need. Less than one percent of the general population has free access to psychotropic medicines. For those paying out of pocket, antipsychotics cost 12% of the daily minimum wage, with antidepressants costing 16% of the daily minimum wage. There is no coverage of mental disorders under social insurance.[lxxxiii]

Health makes up 5.2% of the national GDP of Afghanistan, allowing a budget of $290 million. Of 2004's total health budget, only $0.1 million was directed for mental health.[lxxxiv] The limited mental health resources allocated each year often go to the mental hospital, creating a situation of dire underfunding of inpatient and outpatient facilities.[lxxxv] NGO funding now provides basic services to 85% of Afghanis, but lack of quality data on mental health problems and a scarcity of human resources has inhibited development of cost-effective mental health intervention.[lxxxvi]

There are only two psychiatrists practicing in Afghanistan, and neither work in mental health facilities.[lxxxvii] In total, there are a mere 0.5 workers per 100,000 population. This breaks down to 0.008 psychiatrists, 0.24 non-psychiatric doctors, 0.14 nurses, and 0.16 mental health workers. There are zero psychiatrists, psychologists, social workers or occupational therapists working in outpatient facilities, community-inpatient facilities, or in the mental hospital.[lxxxviii] The WHO's minimum recommendation is 0.4 psychiatrists per 100,000 – that means Afghanistan is recommended to minimally have 140 psychiatrists in the mental health field for

their population of 35 million, but as of the most recent high quality reports in 2005, they had none. There also were zero psychiatrists or psychologists graduating from educational institutions in the year of that report, showing that the void is not being filled.

The only mental hospital is in the capital city, with sixty beds. However, 78% of the population is rural. As of 2006 there was no development of community mental health facilities in rural regions.[lxxxix]

Policy

The Mental Health Strategy was set in place in 2005, with the intention to integrate mental health care, increase promotion of mental health care, and reduce stigma by the year 2020.[xc] The first stage would be to establish a mental health unit within the general health care department. In 2009 Afghanistan expanded to its Mental Health Strategy to include mental health treatment and counseling training manuals for doctors; basic counseling manuals for nurses, midwives, health supervisors, and community health workers in English and Dari; and one year curriculums developed for training of psychosocial counselors.[xci] This was one bright sign in Afghanistan's mental health picture, with some success coming in the pilot programs. The programs succeeded in increasing capabilities to identify and report mental health disorders.[xcii] The main funder of the program is the EU.

Culture

The lack of mental health awareness and the institutional failure to support those with illnesses has created stigma and human rights violations that have gone unaddressed. There is no financial or legislative support for those with psychiatric problems in Afghanistan. WorldBank has stressed the importance of building education and awareness in the country, considering it the affordable and reasonable prerequisite to changing policy (WorldBank 2). However, there is no coordinating body of mental health awareness campaigns, nor any interagency collaboration.[xciii] There has been no successful promotion of equal access to mental health services.[xciv]

Afghanistan has a human rights body, but it only reviewed one patient protection claim in the closely examined year of 2004.[xcv] There is neither supervision nor monitoring systems in

place across the mental health regime, and no training or working sessions on human rights for staff of mental health institutions.[xcvi] This lack of awareness on the ground is particularly dangerous because 40% of all mental health admissions are involuntary, which could promote a culture of conflict between staff and patients. Hospitals do not report involuntary admissions, restraining of patients or duration of stay.[xcvii]

The greatest mental health stigma reported was the stigma towards epilepsy, which is classified in Afghanistan as a mental health disorder. The stigma is so harsh that these individuals are considered in need of both therapeutic treatment and psychosocial counseling to rebuild self-esteem.[xcviii]

As a result of little awareness and cultural support, people most often turn to Islam to cope. The most common coping methods in a survey of the general population were reading the Quran (37%), praying (28%), and talking to family (9%). In Eastern Afghanistan, 98% said that Allah is their main emotional support when they are sad, worried, or tense.[xcix]

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Iran

The integration of mental health policy in Iran has demonstrated a strong political will and dedication to creating proper infrastructure to meet mental health needs, but greater funding would be beneficial to help reach the rural population and build the human rights protection regime.[c] 3% of the country's health care expenditures go to mental health.

The government provides no national data on mental health disorders. Independent findings show that 25.9% of women and 14.9% of men are likely cases of mental illness. The prevalence rate climbs to 31.5% for those over age 65, and 42.4% for divorced or widowed individuals. The social group with the highest risk of mental illness was the unemployed, who were 1.8 times more likely to be at risk of mental disorder than the employed population.[ci]

Access

53% of the population has free access to essential psychotropic medicines. For those paying out of pocket, antipsychotics cost 4% of minimum daily wage, and antidepressants cost 2% of minimum; this is a relatively low cost compared to comparable Middle Eastern countries. All mental health outpatient facilities had at least one psychotropic medicine of each class consistently available on-site or at a local pharmacy.[cii]

66% of Iran's population is urban, 34% rural. The equity in care between urban and rural has improved greatly over the last twenty years, but it is still not fully balanced. There are still two times more psychiatric beds per capita in cities compared to rural areas.[ciii] This may be in part due to the concerted effort to provide free services to the urban poor of Iran. This program is impressive but not incredibly effective, as the services are utilized by the urban poor at a low rate.[civ]

There are 61.2 mental health workers per 100,000 Iranians, far exceeding Iran's geographical neighbors. This includes 1.2 psychiatrists, 2 psychologists, 10.7 non-psychiatric doctors, and 7.8 nurses per 100,000 Iranians. The outpatient facilities in the country are active, treating nearly 1 in 100 of general population. The day treatment facilities see 2.78 people per 100,000.[cv] Community-based facilities have 2 beds per 100,000 population, community residential facilities have 5 beds per 100,000, and mental hospitals have 8 beds per 100,000.

Policy

Iran's success can be attributed in part to its reasonably well-established policy. It has been in place since 1986, and focuses on advocacy, promotion, prevention, treatment, and rehabilitation.[cvi] Under this policy, Iran has developed community services, built psychiatric wards in general hospitals, improved the human rights protection for its users, increased equity of access, and built a monitoring system.[cvii] It also includes a disaster preparedness plan for mental health, based on a late 1990s need assessment on the mental health systems required following an earthquake. The policy has led to improved skills of workers and rural services, and has successfully integrated mental health into the primary health care system.[cviii]

Culture

Education and awareness has been a priority in Iran. There is a coordinating body that exists to oversee public awareness campaigns. In recent years there have been promotion efforts from government agencies, NGOs, professional groups, private trusts, and international agencies.[cix] The country has celebrated Mental Health Week at the end of October each year since 1985, which serves as an annual time for a focused push for awareness.

There have not been many reports of stigma from studies by international agencies, and stigma went unmentioned in the WHO-AIMS 2004 report. However, interviews with mental health patients in 2011 shows that they feel they are discriminated against and cannot fit in to society. More than half of those interviewed tended to agree with statements such as "I am disappointed in myself for having a mental illness," and "negative stereotypes about mental illness keep me isolated from the normal world."[cx] In a subjective self-assessment, 40% of Iranians surveyed with mental illness felt moderate to severe stigma, while another 40% felt mild stigma. While Iran has succeeded in public awareness campaigns, this research suggests that the average Iranian with mental illness feels unwelcomed in Iranian society.

Human rights protection is an area of relative weakness for the Iranian mental health system. There are no laws to prevent against discrimination, including dismissal or lower wages, for individuals with mental illnesses. Legislation exists to obligate employers to hire a certain

number of mentally retarded individuals, but it is not closely enforced. As of 2005, there is no review or inspection process to ensure human rights in mental health facilities.[cxi] The mental health regime as a whole lacks equity for non-Persian speakers, who struggle to find care in the system due to the overwhelming dominance of Persian language in Iranian culture.[cxii] This is a place for improvement in an otherwise strong mental health care system.

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Iraq

Iraq has worked to raise the bar of its mental health care, but has come up short in its availability of drugs and human resources, its rural access, and its equality of access.

Access

Health makes up 3.2% of GDP in Iraq. All National Health Service is free, theoretically allowing for complete access to medications. In reality, though, there is a limited supply of drugs. For example, for a two month period in 2004 there was no access to antiepileptics. Out of pocket, antipsychotic drugs cost 10% of daily minimum wage, and antidepressants cost 8% of one day of minimum wage.[cxiii] It is unclear whether the aforementioned shortage is only for the drugs supplied by the National Health Service, and whether it is still possible during these times of limited supply to buy drugs at the out of pocket price.

There are a total of 1.6 mental health professionals per 100,000 population. This includes 0.33 psychiatrists (falling below the WHO recommendation of 0.4), 0.02 non-psychiatrist doctors, 0.53 nurses, and 0.05 psychologists.[cxiv] The country's facilities include 25 outpatient mental facilities, 4 for children only.

The urban-rural care divide is notable in Iraq. There are four times more beds in Baghdad than other parts of the country, and limited rural mental health access.[cxv] 97% of psychiatric beds are in or near Baghdad. In 2008, the country began a new project to build three community-based social and mental support facilities in northern Iraq, primarily to meet the needs of women and girls affected by the war.[cxvi] This was a strong improvement for access in northern Iraq.\

Policy and Education

There have been recent small steps made to improve policy and education. In 2005, new legislation focused on access to care, rights of family and caregivers, guardianship issues, overseeing treatment practices, and mechanisms to implement new laws.[cxvii] It lacked any provision, though, to combat employment or housing discrimination. Iraq has had a history of moderate inequity regarding access to care for linguistic, ethnic, and religious minorities.[cxviii]

There is a mental health council that oversees education and awareness campaigns. It has recently chosen to target awareness campaigns towards teachers and religious leaders. The council has also made campaigns targeting professional groups, health care providers, and social service staff in the past.[cxix]

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West Bank and Gaza

The Occupied Palestinian Territories (oPt) spends $2.5 million annually on mental health, 73% on mental hospitals. The health care system across the territories is still rather fluid, and was categorized by the WHO as being in "the evolution/development stage," and that the prevalence of infectious disease deaths are being phased out.[cxx] One of the greatest concerns is addressing trauma in the region, as seen in this Doctors Without Borders video series. The oPt have better hopes for improvement than comparable countries, though, because the investment of outside countries and NGOs are helping to support the implementation of a well-developed policy to be implemented in the near future.[cxxi]

Access

The population has free access to essential psychotropic drugs. For anyone needing to pay out of pocket, antipsychotic medication would cost 23% of the daily minimum wage, and antidepressants would cost 15%. Both mental hospitals also have consistent access to at least one form of each psychotropic drug. The hospitals have been unable to maximize their cooperation, as the hospitals in the West Bank and Gaza are under separate structures within the Ministry of Health.[cxxii]

Sixty percent of the population lives in villages or refugee camps.[cxxiii] However, 88% of psychiatry beds are in or near the largest city. Rural populations have considerable trouble accessing mental health care for serious needs. The active conflict also makes access difficult, as seen in the violence at the Bethlehem Mental Hospital in 2004.

Human Resources

There are a relatively strong number of human resources in the mental health field, with a total of 7.31 human resources per 100,000 population. This includes 0.87 psychiatrists, 0.98 psychologists, and 3.43 nurses per 100,000. 57% of all workers are in the public sector, working for the Ministry of Health, with the other 43% working in the nongovernmental sector. Schools are still consistently graduating psychiatrists and nurses, and none of the psychiatrists have emigrated to other countries following graduation.[cxxiv]

Only 1% of medical doctors' training is devoted to mental health, but 9% of nursing training is devoted to it. There is a similar imbalance of retraining, with no primary care doctors receiving mental health refresher courses, but 27% of unspecialized mental health workers receiving refresher training.

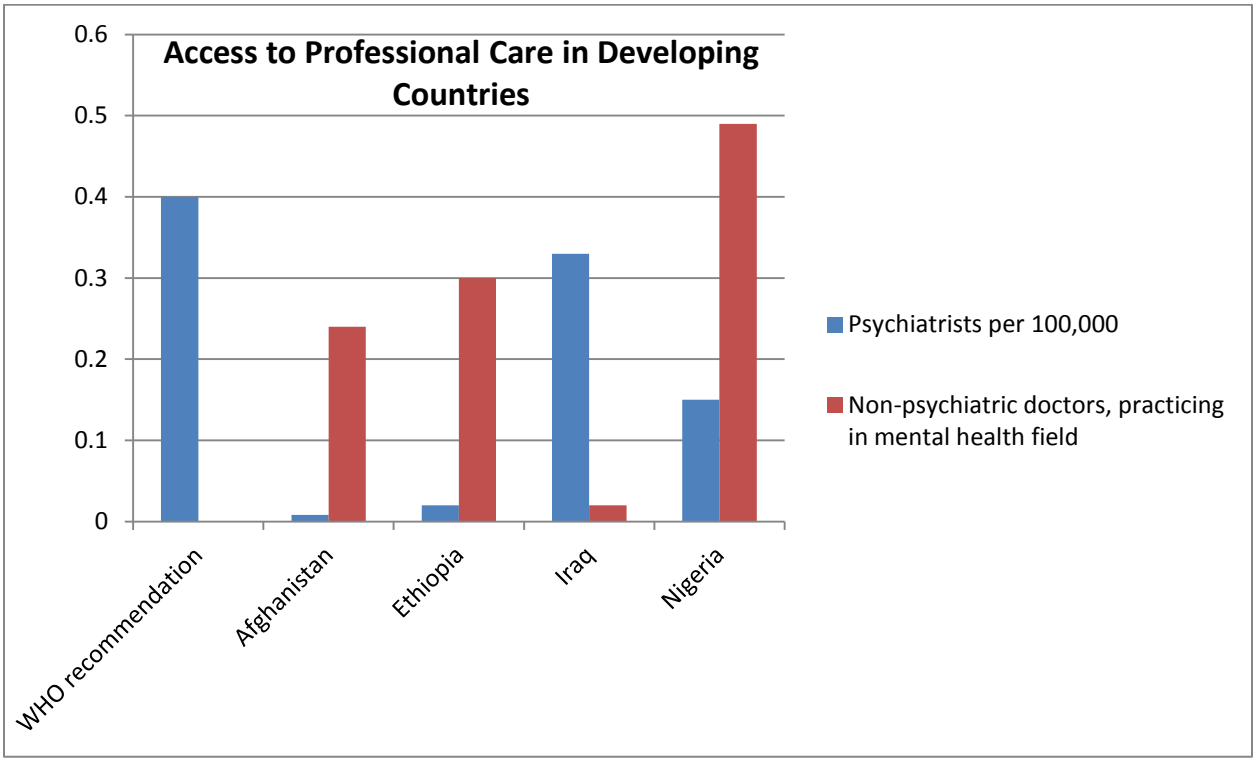
Culture

There are human rights organizations at work in oPt, but none of them have the authority to oversee or impose sanctions on mental health professionals. This is worrisome, considering that the most recent figures from 2005 show that 40% of all mental hospital admissions are involuntary. There are plans for future legislation to put a human rights monitoring body in place.[cxxv]. There is a monitoring system in place that collects basic data from all mental health facilities including beds, admissions, lengths of stay, and patient diagnoses.[cxxvi]

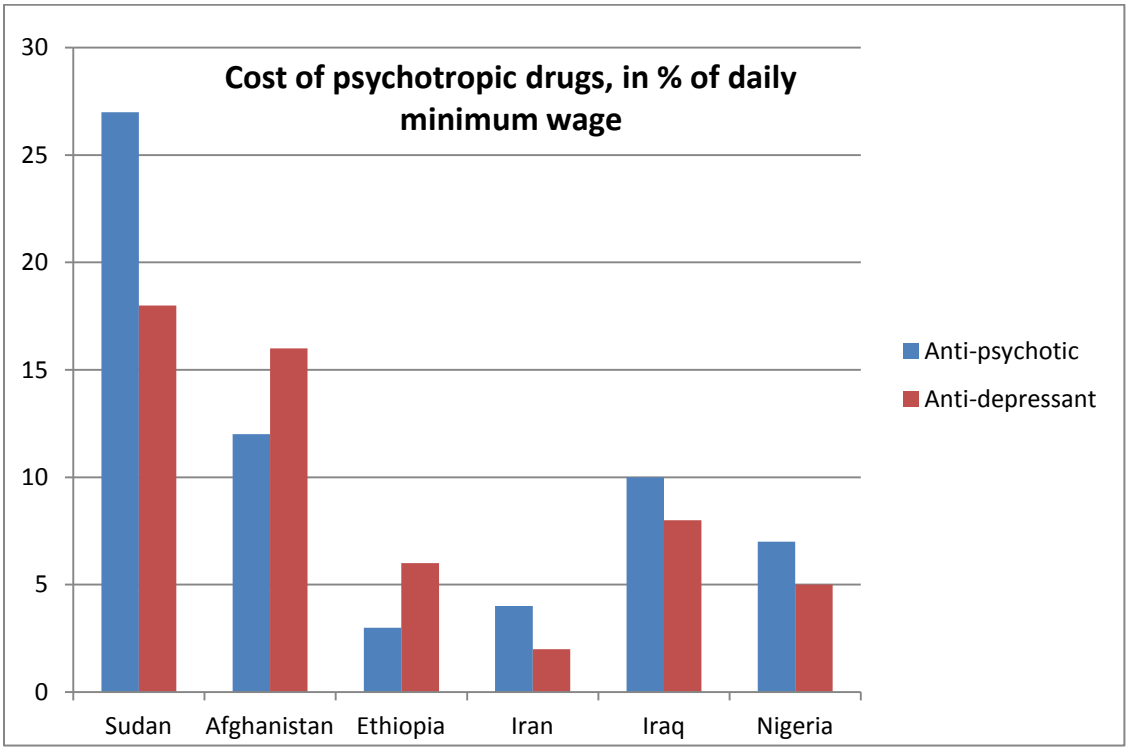
Mental health awareness has been promoted by an array of organizations including UNICEF, WHO, and the French and Italian Cooperations. They have chosen to target teachers, health care providers, and the general public, but have not made any attempt to reach the vulnerable populations of women, adolescents, and trauma survivors.

ANNEX I

Professional Care Chart:



Cost of Drugs Chart



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