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## 芝加哥大学国际中学生模拟联合国大会

# World Health Organization (WHO)

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# MUNUC-SFLS 2023

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# CHAIR LETTER

Dear Delegates,

Hello! A warm welcome to MUNUC! My name is Kait Albarran, and I will be your chair for the World Health Organization (WHO). I am a third-year at the University of Chicago from San Antonio, Texas, majoring in Biological Chemistry on the pre-medical track with a minor in Linguistics. As far as extracurriculars, I am involved not only in MUNUC (for which I am currently the Under-Secretary-General for hybrid committees for MUNUC 36), but also in the college equivalent of MUNUC, ChoMUN, for which I am a Crisis Director. Additionally, I am involved in the Organization of Latin American Students. When I'm not doing homework or MUN-related work, I spend my time planning wacky study breaks (I'm a resident assistant for May House!), talking about the great state of Texas, and wishing it were warmer outside.

The topic of this committee, mental health in developing nations, is one of great importance; ensuring equal access to mental health resources is an essential step in working towards the third goal of the United Nations Sustainable Development Goals, which is to "ensure healthy lives and promote well-being for all at all ages."[1] As a pre-medical student, I take all kinds of health seriously. Thus, I feel very fortunate to have the opportunity to learn more about mental health along with all of you. I am always greatly impressed by the thorough research that all of you conduct and all of your creative solutions to the issue at hand.

Furthermore, I am very much looking forward to meeting all of you and watching your development over the course of the conference. If you have any questions at all, whether about committee content or anything conference-related (or even if you just want to say hello!), please do not hesitate to send me an email. See you all soon, and may your research and preparation be fruitful!

[1] "Goal 3 | Department of Economic and Social Affairs." United Nations. Accessed November 19, 2023. https://sdgs.un.org/goals/goal3.

Good luck and best wishes to y'all,

Kait Albarran (she/her)

kalbarran@uchicago.edu

# HISTORY OF COMMITTEE

The World Health Organization was formed on April 7th, 1948. Pioneered by Chinese, Brazilian, and Norwegian delegates at the 1945 United Nations Conference on International Organization, the World Health Organization was the first specialized agency of the United Nations to be subscribed to by every UN member country. Since its founding, the WHO has been instrumental in global health causes, establishing the first international epidemiological information service, drastically reducing global deaths from measles, and contributing to the total eradication of smallpox in 1979.

The original priorities of the WHO established in 1948 were malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering, and nutrition. Currently, the WHO is involved in everything from preventing Ebola outbreaks, to promoting road safety to training healthcare workers how to respond to natural disasters. The WHO meets annually in its headquarters in Geneva, Switzerland. At these meetings, WHO delegates, along with observers from various non-governmental organizations, meet to discuss global health issues and draft resolutions.

# TOPIC A: MENTAL HEALTH IN DEVELOPING COUNTRIES

## Statement of the Problem

Poor mental health is an issue that affects people worldwide, regardless of age, gender, or socioeconomic status. Currently, it is the leading cause of disability worldwide and represents 14% of global health conditions.[2] There are hundreds of different kinds of mental illnesses, but the World Health Organization recognizes eight "priority diseases."[3] These have been determined by taking into account the economic cost of these diseases as well as prevalence and association with human rights violations.[4] These priority diseases are: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs and mental disorders in children.[5]

These diseases are particularly troubling in developing countries–75% of the global burden of mental illness comes from developing countries.[6] Disease burden measures the prevalence of the disease, but it also takes into account the harm caused by that disease.[7] For example, disease burden measurements often use Disability-Adjusted Life Years (DALYs) to measure lifespan.[8] Disability-Adjusted Life Years take into account not only years lost from life due to mortality, but also years lost due to living life at sub-optimal health.[9] Other factors that are taken into account when calculating disease burden are financial cost, both to the individual and the healthcare system, as well as the individual's overall quality of life with the disease.[10] So the fact that the burden of mental illness is higher in developing countries does not necessarily indicate that mental illness is more prevalent in those countries. More likely, this is due to the fact that in developing countries, mental

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[2] Chambers, Andrew. "Mental illness and the developing world." *The Guardian*. May 10, 2010. Accessed April 26, 2017.
[3] World Health Organization. United Nations. *Mental Health Gap Action Programme.* Geneva, Switzerland: WHO Document Production Services, 2008.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Lajoie, J. "Understanding the Measurement of Global Burden of Disease." *National Collaborating Center for Infectious Disease*. February 2015.
[8] Ibid.
[9] Ibid.
[10] Ibid.

illness more greatly affects an individual's quality of life and is more difficult for those countries to manage.

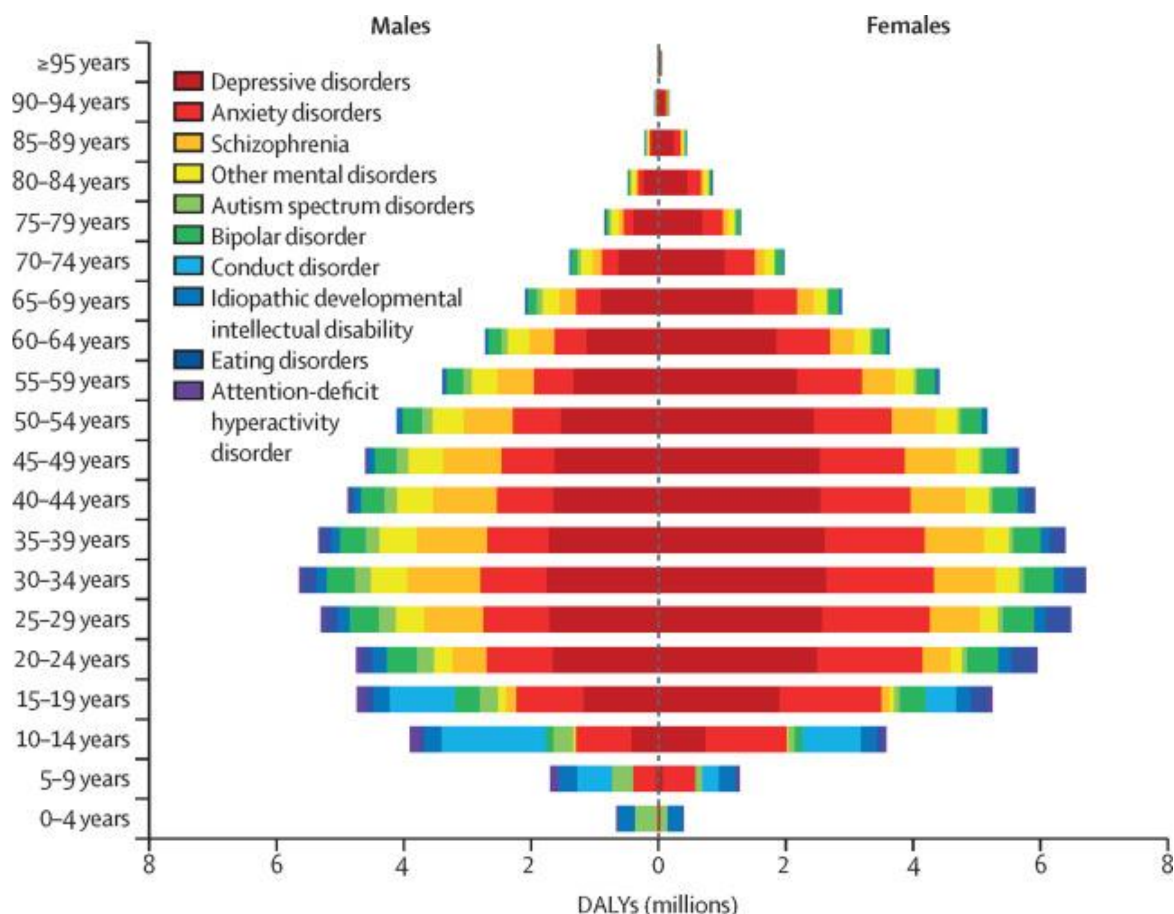


*Figure 1:* Leading causes of DALY adjustments globally, by mental disorder, sex, and age, 2019.[11]

***Risk Factors in Developing Countries***

One of the reasons why mental illness is more problematic in developing countries is because a vicious cycle tends to arise between poverty and mental illness. People in poverty are often unable to get proper treatment for their illness. It is estimated that 75-85% of people with mental illnesses in

[11] GBD 2019 Mental Disorders Collaborators. "Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019," *The Lancet*, vol. 9, no. 2, February 2022, pp. 137-150. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(21)00395-3/fulltext.

developing countries lack access to proper medical care, which exacerbates the mental illness.[12] These same people then have greater expenses and are often unable to work full-time, which exacerbates their poverty.[13] There are also additional factors that feed into this cycle of poverty and mental illness. People with mental illness are more likely to become the victims of physical and sexual abuse.[14] This abuse can worsen their mental illness and impact their ability to provide for themselves, especially if they already live in poverty. Another factor is education. Children with a mental illness are less likely to complete their education which can impact their ability to get a well-paying job as they grow older.[15] Overall, this cycle means that people in poverty who also suffer from a mental illness are more impacted by their illness and less able to seek treatment.

Besides poverty, there are additional factors that put people at risk for developing or being more greatly impacted by mental illness, especially in developing countries. One of these factors is political instability. It is estimated that in situations of armed conflict, 10% of people who experience trauma will develop some mental illness, and an additional 10% of people will develop lasting mental trauma that may not manifest itself as a mental illness.[16] **Post-Traumatic Stress Disorder (PTSD)**, a condition of mental distress following a traumatic event, is very common in areas experiencing war or other armed conflict. For example, during the Gulf War, a study found that 80% of Kurdish children and 60% of their caregivers exhibited symptoms of PTSD.[17] In addition to war, displacement can take a toll on the mental health of refugees. In a study conducted on refugees in Germany, psychologists found that more than half of refugees who had arrived in the past year showed signs of a mental disorder, with a quarter of them suffering from depression, anxiety, or PTSD.[18] Additionally,

[12] "Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group" *UN(DESA) - WHO Policy Analysis*. September 12, 2010.
[13] Ibid.
[14] *Gap Action Program*, 2008.
[15] *WHO Policy Analysis*, 2010.
[16] Murthy, R and Lakshminarayana, R. "Mental health consequences of war: a brief review of research findings." *World Psychiatry*. 5(1): 25–30. 2006.
[17] Ahmad A, Sofi MA, Sundelin-Wahlsten V, von Knorring AL. "Posttraumatic stress disorder in children after the military operation 'Anfal' in Iraqi Kurdistan." *European Child Adolescent Psychiatry.* 9(4):235-43. 2000
[18] Abbot, A. "Refugees Struggle with Mental Health Problems Caused by War and Upheaval." *Scientific American*. October 11, 2016.

war and upheaval can restrict access to medical care, preventing people with mental disorders from accessing treatment and therefore worsening their condition.[19]

Physical health can be another factor. Poor physical health can be both a cause and a symptom of mental illness.[20] For example, people with **HIV/AIDS** have a much higher rate of mental illness than people without. A study found that 22-45% of people suffering from HIV/AIDS have symptoms of depression, while only 5-17% of the general population do.[21] People with HIV/AIDS are also at a much greater risk for developing psychosis and anxiety disorders.[22] Furthermore, people with a mental illness can also be at a greater risk for developing HIV/AIDS, as those people are more likely to engage in behaviors like unprotected sex and drug use.[23] Since 95% of HIV/AIDS cases occur in the developing world, this puts people in those countries at a greater risk for developing and being more greatly impacted by mental illness.[24] Substance abuse is another risk factor in mental illness. Substance abuse and mental illness are comorbid, meaning they often occur simultaneously in the same person.[25] The causality can flow in either direction, but most studies indicate that people with a mental illness are twice as likely to develop a substance abuse problem, and people with substance abuse problems are twice as likely to develop a mental illness.[26] These disorders can often arise from the same environmental triggers, like trauma or abuse, and affect very similar parts of the brain, so their comorbidity is not surprising.[27] Substance abuse problems are not as common in low-income countries as they are in high-income countries, but drug and alcohol use in those countries is on the rise, meaning that those people will run a higher risk of developing or exacerbating a mental illness.[28]

An additional risk factor is gender, particularly in countries with a large amount of gender inequality. Globally, women carry a greater burden of mental illness than men.[29] In many developing countries,

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[19] *Gap Action Program*, 2008.
[20] Petersen, Inge, Arvin Bhana, Alan Flisher, Leslie Swartz, and Linda Richter. *Promoting Mental Health in Scarce-Resource Contexts*. Capetown, South Africa: HSRC Press, 2010.
[21] Hammond, E. "HIV and Psychiatric Illness." *Psychiatric Times*. December 01, 2007.
[22] Ibid.
[23] World Health Organization Secretariat. "HIV/AIDS and Mental Health." November 20, 2008.
[24] "HIV/AIDS." World Health Organization. *World Health Organization*. 2017.
[25] "Comorbid Drug Abuse and Mental Illness." Public Information and Liaison Branch - National Institute on Drug Abuse. June 2007.
[26] Ibid.
[27] Ibid.
[28] Bell, Bethany. "Developing World Drug Use 'Up'" *BBC News*, *Vienna*. September 8, 2007. Accessed May 6, 2017.
[29] Petersen et al, 2010.

women face more barriers to medical treatment, and are at a greater risk for developing mental illness due to gender-based violence and a poorer social status in some regions.[30] Furthermore, especially in the developing world, women are overrepresented among those in poverty. According to the United Nations Development program, women make up over 70% of those in poverty around the world, so they are more likely to face the barriers and risks associated with poverty.[31] Additionally, many of the behaviors encouraged or even required of women in countries with gender inequality, such as behaving submissively or perceiving oneself as subordinate, are strongly related to mental illnesses like depression.[32]

### *Addressing Global Mental Health Disparities*

Currently, mental illnesses are not given sufficient attention by the UN and especially not in developing countries. Globally, only 2% of national health budgets are allocated towards mental illness, and 21% of countries allot less than 1% of their national health budget towards the issue.[33] These funds are disproportionately small for a group of diseases that have a burden 1.5 times greater than cancer and 7 times greater than infectious diseases.[34] Furthermore, mental health is not mentioned anywhere in the Millennium Development Goals, eight goals set by the UN for international development to be met by the year 2015.[35] Within the goal of combatting diseases, the specific goals of eradicating HIV/AIDS, malaria and tuberculosis are detailed extensively.[36] While these are, of course, important issues, the fact that mental illness is not brought up at all indicates the international community's overall complacency towards this issue.

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[30] *Gap Action Program*, 2008.
[31] UNDP. (1995) Human Development Report. New York: Oxford University Press.
[32] Gilbert, P. and Allan, S. "The role of defeat and entrapment (arrested flight) in depression: an exploration of an evolutionary view." *Psychological Medicine*. 28: 585-598. 1998.
[33] *Gap Action Program*, 2008.
[34] Crowe, Kelly. "Mental illness impact said to be greater than cancer." *CBC News*. October 10, 2012. Accessed July 19, 2017.
[35] World Health Organization. United Nations. *Health and the Millennium Development Goals*. Geneva, Switzerland: WHO Document Production Services, 2005.
[36] Ibid.

*Figure 2*.[37]

One reason for this complacency is the fact that mental illness is simply not as "glamorous" an issue as other diseases. A study by Save the Children found that individuals will care more about an issue if they are presented with an individualized picture of the problem, rather than a statistic.[38] For physical diseases, it is easy to show potential donors a picture of someone suffering from those symptoms as a way to invoke sympathy. But mental diseases rarely have the sort of external symptoms that can be captured in a photograph, so they fail to garner the same sort of sympathy, even though individuals may be affected by that mental illness just as much as they would be by a physical one.

Furthermore, there is a severe stigma surrounding mental illness. 70% of people with a mental illness report facing discrimination due to their condition, and this proportion is even higher in developing countries.[39] This stigma can come from a number of places. People with mental illnesses are often

[37] UNAMID/Flickr. Via *Mad in America*. December 2018. https://www.madinamerica.com/2018/12/integrating-traditional-healing-practices-response-global-mental-health-disparities/.
[38] Chambers, 2010.
[39] Ibid.

regarded as being particularly dangerous or aggressive which can create distance between the ill person and their community.[40]

In some cultures, mental illnesses are seen as a form of demonic or spiritual possession. For example, in Uganda, children who exhibit symptoms of a dissociative disorder are thought to be suffering from cen, a form of spiritual possession where the ghost of a deceased person inhabits a living person and replaces their identity.[41] Reports of cen are especially common in child soldiers: boys as young as 12 who have been kidnapped to serve in The Lord's Resistance Army are much more likely to suffer from PTSD.[42] Explaining mental illnesses through supernatural reasoning is harmful for two reasons, as it further contributes to the stigmatization of the individual and prevents that individual from getting proper treatment for their illness.[43]

***Country-Specific Approaches to Mental Health***

There are many problems with the way mental illness is treated in developing countries. The first problem is a lack of standardization for mental illness diagnosis, as standards for classifying mental illness varies heavily from country to country. Many countries do not consider diseases like depression or anxiety to be mental illnesses, while others solely focus on psychiatric symptoms of mental illness and do not recognize physical symptoms to be related to mental illnesses.[44] The WHO frequently publishes a diagnostic guide for mental illnesses as a part of the International Statistical Classification of Diseases and Related Health Problems, which would be a very useful tool for globally standardizing mental illness diagnosis; however, it is underused by physicians in favor of country-specific diagnostic guides.[45]

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[40] Lauber, C and Rössler, W. "Stigma towards People with Mental Illness in Developing Countries in Asia." *International Review of Psychiatry*. 19(2):157-78. 2007.
[41] Fernando, Suman. *Mental health worldwide: culture, globalization and development*. Basingstoke: Palgrave Macmillan, 2014.
[42] Davey, Graham. "'Spirit Possession' and Mental Health." *Psychology Today*. December 13, 2014. Accessed July 20, 2017.
[43] Fernando, 2014.
[44] Jacob, K.S. "Community care for people in developing countries." *The British Journal of Psychiatry.* 178.4.296. 2001
[45] Reed, Geoffery M. "Toward ICD-11: Improving the clinical utility of WHO's International Classification of mental disorders." *Professional Psychology: Research and Practice*. 41(6): 457–464. 2010

Another issue with standardizing mental illness diagnosis is the fact symptoms of mental illness can vary between cultures. For example, schizophrenic patients who hear voices vary in what types of voices they report depending on their culture. Patients in the United States are more likely to report hearing the voices of strangers giving them violent commands, while patients in India and Ghana report hearing the voices of family members or close friends sometimes saying horrible, violent things, but more often hear them giving advice or gentle scolding.[46] This is true for other illnesses as well.

North America and East Asia have similar rates of depression, but in North America, patients are more likely to report psychological symptoms of depression (e.g., feelings of sadness, low self-confidence) while East Asian patients are more likely to report physical symptoms such as fatigue or insomnia.[47] Whether this is because either group is simply more likely to report those particular symptoms or whether they actually experience the illness differently is unknown, but these examples clearly show a need to tailor diagnoses somewhat towards the culture of the patient.

This phenomenon can be seen even more clearly in the modern age because as globalization fundamentally alters cultures around the world, it also changes the way people in those cultures exhibit mental illnesses. For example, before 1994, **anorexia** in China looked very different from the way it looked in the West. While both illnesses would lead people to severely restrict their food intake, people in the West were doing so because they wanted to lose weight while people in China reported that their stomachs constantly felt full and bloated.[48] The disease was also much less common in China than it was in the West.[49] However, in 1994, a young girl suffering from anorexia collapsed on the streets of Hong Kong and died. In reporting the story, Chinese journalists cited American diagnostic manuals on the definition of anorexia and consulted Western psychologists who described the disease from the Western point of view.[50] Suddenly, the number of people suffering from anorexia exploded and patients began to report the same weight-gain phobia that

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[46] Luhrmann, T et al. "Differences in voice-hearing experiences of people with psychosis in the U.S.A., India and Ghana: interview-based study." *British Journal of Psychiatry*. 206(1):41-4. 2015.
[47] Centre for Addiction and Mental Health. "Culture And Depression." *ScienceDaily.* 15 July 2008.
[48] Watters, E. "The Americanization of Mental Illness." *The New York Times Magazine*. 8 January 2010.
[49] Ibid.
[50] Ibid.

was characteristic of Western anorexia.[51] The link between culture and mental illness was strong enough to fundamentally shift the **epidemiology** of this disease and create an outbreak of eating disorders in China.

### *Disparities in Treatment*

Another contributing factor to the greater burden of mental illness in developing countries comes from the way mental illnesses are treated in those countries. Developing countries are highly reliant on psychiatric hospitals and asylums to treat mental illnesses, which is problematic for a few reasons. Firstly, hospitals are highly centralized treatment centers that are typically located in areas with dense populations. This means that people in rural areas rarely have access to these medical centers and therefore have no option for mental illness treatment.[52] Secondly, hospital and asylum treatment require that patients are removed from their homes and live in the treatment center. This complete separation from family and familiar surroundings can exacerbate existing mental problems and hinder treatment.[53] Psychiatric hospitals are also very expensive, which is a barrier to treatment for people in poverty.[54]

[51] Ibid.
[52] *Gap Action Program*, 2008.
[53] Ibid.
[54] Jacob, 2001.

*Figure 3*. A person chained outdoors.[55]

Patients in psychiatric hospitals and asylums are also frequently the victims of human rights violations. The combination of poorly-funded institutions and the stigmatization of mental illness means that mentally ill people seeking treatments are often subjected to abuse and neglect.[56] For example, a report from the Jakarta Social Agency found that in four shelters for people with mental illness, 181 people died of malnutrition in a seven month period.[57] In a psychiatric hospital in Ghana, 300 people were locked in a set of cells meant to house 50.[58] The men were also frequently chained outside and beaten and whipped by hospital employees.[59]

It is important to note that human rights violations in mental illness treatment centers is not isolated to developing countries. Investigations into a New York psychiatric hospital found that patients were restrained unnecessarily, ignored during medical emergencies, and subjected to sexual abuse from

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[55] United Nations. "Mental Health and Development." https://www.un.org/development/desa/disabilities/issues/mental-health-and-development.html.
[56] Mfoafo-M'Carthy, Magnus and Huls, Stephanie. "Human Rights Violations and Mental Illness: Implications for Engagement and Adherence." *Sage Journals*. 4:1. 2014.
[57] World Health Organization. United Nations. *Mental Health and Development.* Geneva, Switzerland: WHO Document Production Services, 2010.
[58] Ibid.
[59] Ibid.

employees and other patients.[60] Not only does this abuse violate the human rights of the patients, but it also discourages other people with mental illnesses from seeking treatment for fear of experiencing the same abuse.

[60] Hartocollis, Anemona. "Abuse Is Found at Psychiatric Unit Run by the City" *The New York Times*. February 5, 2009.

# History of the Problem

***Early Theories of Mental Illness***

Mental illness has afflicted humans for thousands of years. As far back as 6500 BCE, there are early accounts of people using a procedure called **trepanation** to cure possession by evil spirits, which was likely a supernatural explanation for a mental illness like schizophrenia.[61] The first evidence of people exploring mental illness in the context of medicine as opposed to religion or superstition comes from Hippocrates in 400 BCE. Hippocrates believed that mental illness fell into four categories: epilepsy, mania, melancholia, and brain fever, and that they were caused by an imbalance of fluids in the body.[62] Hippocrates and his theory of **humorism** were eventually proven wrong but he paved the way for more medical approaches towards mental illness, though many cultures continued to view mental disorders through the lens of superstition.[63]

In Europe, the establishment of asylums to treat the mentally ill began in the 16th and 17th centuries. These asylums were created not to treat mentally ill people, but to keep them away from the general public and prevent them from hurting others or themselves.[64] Europe's first and oldest asylum is St. Mary of Bethlehem in London, more commonly known as Bedlam.[65] The facility is still an operating psychiatric hospital, but until the mid-20th century, the asylum kept inmates in horrid conditions: chaining them to the wall, keeping them in filthy rooms, and not giving them clothing.[66] The reason for this maltreatment, and the guiding philosophy for many asylums at the time, was that mentally ill people were regarded as animals, with no self-control or higher reasoning capabilities.[67] In order to treat them, one had impose a strong authority and abuse the patients in

[61] Restak, R. *Mysteries of the mind*. Washington, DC: National Geographic Society. 2000.
[62] Farreras, I. G. History of mental illness. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology.* Champaign, IL: DEF publishers. 2017.
[63] Ibid.
[64] Porter R, 'Madness and its institutions', in A Wear (ed.), *Medicine in Society*(Cambridge: CUP, 1992), pp 277-301.
[65] Ibid.
[66] Andrews, Jonathan. *Bedlam Revisited: A History of Bethlem Hospital c.1634 – c.1770* [Ph.D. thesis]. London: Queen Mary and Westfield College, London University; 1991.
[67] Farreras, 2017.

order to shock them into recovery.[68] Although most medical workers have a different view of mental illness now, many psychiatric hospitals have not been able to escape this historical legacy of abuse.

***Legacies of Colonization***

In most developing countries, the way mental illness was handled - among many other health and social issues - changed drastically during periods of colonization.[69] For this reason, it is helpful to explore the history of mental illness in those countries in three eras: pre-colonialism, during colonialism and postcolonialism. Precolonial mental illness treatment varies from culture to culture, but a few overarching trends stand out. Traditional medicine in precolonial eras tended to stay within smaller communities and emphasize spiritual well-being in addition to physical health in dealing with mental illnesses. For example, many indigenous African medicine focuses around healers, members of the community who could serve as intermediaries between the visible world and the invisible world of spirits or ancestors.[70] These healers practiced holistic care by maintaining the physical and emotional well-being of mentally ill people while emphasizing the importance of community support in their healing.[71] In the Asia-Pacific region, until the 19th century, mentally ill patients were treated in their homes by family members, or in religious institutions by spiritual healers.[72]

This trend does not hold true for every developing country, however. For example, as far back as 200 BCE, hospitals were established in India for the purposes of treating the mentally ill.[73] Some of these hospitals treated mental illness as a divine or spiritual condition, but others took a more medical approach and treated them as physical diseases, using diet changes and medicinal treatments to cure the afflictions.[74]

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[68] Ibid.
[69] Fernando, 2014.
[70] Abdullahi AA. "Trends and Challenges of Traditional Medicine in Africa." *African Journal of Traditional, Complementary, and Alternative Medicines*. 8(5 Suppl):115-123. 2011.
[71] Ibid.
[72] Parameshvara Deva, M. "Mental Health in the Developing Countries of the Asia Pacific Region." *Asia Pacific Journal of Public Health*. 11(2):57-59. 1999.
[73] Nizamie SH, Goyal N. History of psychiatry in India. *Indian Journal of Psychiatry*.52(Suppl1):S7-S12. 2010.
[74] Ibid.

*Figure 4*. Psychiatric Teaching Hospital in Freetown, Sierra Leone, previously known as the Kissy Lunatic Asylum.[75]

During periods of colonization, a great shift occurred in how mental illness was treated in these countries. The invading Europeans brought with them European medical practices and philosophies, many of which conflicted with the ways indigenous cultures had been practicing medicine.[76] British colonialists in India established asylums that focused on segregating "lunatics" from the rest of the population, as opposed to treating them in a manner distinctly different from the hospitals previously established in India.[77] In Fiji, the British quickly established psychiatric hospitals to treat patients who previously would have been treated at home.[78] This disruption of traditional medicine practices did not come exclusively from Europeans. When the Japanese colonized Korea in the early 20th century, they established a number of asylums that shared the European philosophy of using institutionalization to control and sequester "deviant" people who ranged from being severely mentally ill to merely defiant.[79] Although these institutions were at least said to have been put into

[75] Partners in Health. Via *The Guardian*. January 2023. https://www.theguardian.com/global-development/2023/jan/17/patients-chained-to-walls-and-beds-freetown-sierra-leone-psychiatric-hospital.
[76] Fernando, 2014.
[77] Sharma S. Psychiatry, colonialism and Indian civilization: A historical appraisal. *Indian Journal of Psychiatry*. 48(2):109-112. 2006.
[78] Minas, H and Lewis, M. *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives.* New York City: Springer Publishing, 2017.
[79] Jun Yoo, T. *It's Madness: The Politics of Mental Health in Colonial Korea.* Oakland, CA: University of California Press. 2016.

place in order to improve the quality of life for the indigenous cultures, this massive upheaval of cultural medical practices led to underdeveloped indigenous systems and an over reliance on centralized, European medical care.

Colonizing countries also abused psychiatric medical practices in order to control indigenous populations and suppress rebellion. For example, in 1932, French psychologists in North Africa reported that Algerians were psychologically prone to anger and violence, which the French government used to justify imposing a stronger military presence in the area.[80] In other areas of Africa, European psychologists described tendency towards rebellion as a symptom of mental illness, meaning that anyone who expressed dissent against the colonizing government could be put into an asylum.[81] This made it much easier for colonial forces to exert greater control over the colonies and perpetuate the racist ideologies that supported European supremacy. Not only did this abuse of medical diagnostics contribute to an unbalanced political system and create an extreme mistrust of psychiatric treatment, but it also meant that more and more people were put in these asylums - asylums which advocated punishment and isolation from the community. As a result, colonial asylums became notoriously overcrowded, which led to poorer living conditions for inmates, and meant that resources that could have gone to treating people with mental illnesses was misused.[82]

It's important to note that these sorts of racism-fueled diagnostics would sometimes swing the other way, and not diagnose people who were mentally ill. Some psychologists held the belief that mental illness could only occur in more highly-developed minds, and that the minds of indigenous people were too crude and animalistic to be vulnerable to mental illnesses.[83] As a result, some physicians would view symptoms indicative of a mental illness in an indigenous person as a defect in their

[80] Keller, R. "Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962." *Journal of Social History*.35(2):295-326. 2001.
[81] Ibid.
[82] Sadowsky, J. "Psychiatry and Colonial Ideology in Nigeria." *Bulletin of the History of Medicine*. 71(1):94-111. 1997.
[83] Smith, L. *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914*. Basingstoke: Palgrave Macmillan Publishing, 2014.

character or as a result of their "fundamentally flawed" civilization and not give that person the help they needed.[84]

The practice of colonialism as a whole also had a noticeable effect on the mental health of the people who fell under colonial rule. The stresses associated with the imposition of imperialist forces caused distress for even those not suffering from a mental illness. Even Western psychologists noted the high prevalence of what they referred to as insanity that occurred as nations became more "civilized" as defined by Europeans.[85] These psychologists determined that the minds of indigenous people were unable to cope with these societal advances and were therefore prone to insanity.[86] Although this idea stereotypes indigenous populations as uncivilized and grossly misunderstands the source of these stressors, it contains a bit of truth. Invasion by outside forces completely uprooted everything these indigenous populations knew. The abuse and human rights violations they suffered daily under colonial rule created a significant amount of stress for the oppressed populations.[87] This amount of stress could aggravate pre-existing conditions in those who already suffered from such disorders and even create mental illness-like symptoms in those who had no disorder. This pervasive mental stress persists even today in post-colonialist countries. Indigenous population around the globe are much more likely to suffer from depression, anxiety, suicide, and substance abuse problems.[88]

Even after colonized countries regained their independence, the cultural and political upheaval presented by colonization had caused irreparable damage to the mental healthcare in these countries. For one, these countries became extremely reliant on Western diagnostics and treatment methods. This is problematic for a few reasons. As stated earlier, the symptoms of mental illnesses vary from culture to culture, as does how well a patient will respond to a certain treatment. Western treatment systems are bound to be less effective when they are applied outside of their cultural context. Another problem with this reliance is that it sets a precedent for a "West knows best"

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[84] Ibid.
[85] Keller, 2001.
[86] Ibid.
[87] Fernando, 2014.
[88] Cohen, A. "The Mental Health of Indigenous Populations - an International Overview." *Cultural Survival Quarterly Magazine*. June 1999.

philosophy that discourages people from seeking help within their community.[89] This philosophy is one reason why asylum care is so prevalent in developing countries and why mentally ill people in those countries have no local community-based resources to turn to.[90]

### *Restrictive Patent Laws*

Another effect of the lasting Western influence in these countries is an over reliance on Western psychiatric drugs. In the 1950s, Western countries began advocating the use of drugs to treat mental illnesses and developing countries soon followed suit.[91] However, the majority of psychiatric drugs were and still are developed in the US and Europe and sold in developing countries at an extremely high markup.[92] In 1967, the concept of pharmaceutical **patents** was introduced by Germany and other Western powers adopted these laws over the next 30 years.[93] Under these patent laws, generic versions of pharmaceutical products could not be developed until the patent expired, which takes a minimum of 20 years but can take even longer in some circumstances.[94] This means that for 20 years, the only course of treatment for people in developing countries with mental illnesses were drugs that they were unable to afford.

[89] Fernando, 2014.
[90] Ibid.
[91] Okpaku, Samuel O. *Essentials of global mental health*. Cambridge: Cambridge University Press, 2014.
[92] Sathyanarayana Rao, T and Andrade, C. "Moving psychopharmacological drug development to the developing world." *Indian Journal of Psychiatry*. 56(2): 105–106. 2014.
[93] Ibid.
[94] Ibid.

# Past Actions

In 2008, the World Health Organization created the Mental Health Gap Action Programme (mhGAP) as a way to fight the effects of mental illness on a global scale.[95] Targeting low- and middle-income countries specifically, this program advocates the use of scale-up strategies in order to create long-lasting, comprehensive solutions for mental healthcare.[96] A scale-up strategy involves looking at **interventions** that are successful on a small scale, and finding ways increase their impact by involving more people, allocating more human and financial resources and creating a system to monitor the impact of that intervention over time.[97] The Gap Action Programme encourages low and middle income countries to adopt mental healthcare into their national health policy and create legislation that will facilitate the scale-up strategy.[98] Such legislation might include policy that requires certain training for mental healthcare professionals or allocates more of the national budget towards mental health care.[99] The Mental Health Gap Action Plan also created specific training criteria for mental health care personnel where primary healthcare doctors and nurses are trained according to the guidelines created by the World Health Organization.[100]

The WHO has already implemented the mhGAP training protocol and scale-up strategy in developing countries with some success. For example, in the Philippines, the WHO collaborated with the International Medical Corps, Save the Children and Médecins Sans Frontières after Typhoon Hayan to expand mental health care in the areas affected by the natural disaster.[101] The strategy involved training people in mental healthcare both at the community level and in general healthcare settings as well as ensuring that trained doctors would have access to psychiatric drugs following the typhoon.[102] By the program's end, in 2014, 91% of provincial hospitals and 98% of rural clinics had at

[95] *Gap Action Program*, 2008.
[96] Ibid.
[97] Ibid.
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] "Scale up of mhGAP across a disaster-affected region in the Philippines." *World Health Organization*. World Health Organization. 2016.
[102] Ibid.

least one person trained in mental healthcare, and more than four million people had access to this care.[103]

The World Health Organization also employed mhGAP training in Guinea following the Ebola epidemic.[104] The WHO trained 320 primary health doctors in the most affected region of Guinea.[105] In addition to expanding access to mental health treatment, this training also encouraged doctors to abandon harmful treatment practices such as physically restraining mentally ill patients and depriving them of human contact.[106] Furthermore, Ethiopia has even used the mhGAP as a guideline for creating national mental healthcare policy. The policy integrates mental healthcare into the existing national healthcare policy, standardizing training programs and employing the scale-up strategy to monitor small **pilot programs** and use those findings to improve national mental healthcare.[107]

The mhGAP is not without criticism, however. Some people are concerned that the mhGAP will not take into account cultural differences between countries and will impose measures that may not be appropriate for some countries. For example, some scholars are concerned at the stringent definition of "community" as just the patient and his or her family.[108] In some cultures, they argue, patients may have stronger relationships with non-blood relatives, and these relationships need to be incorporated in the patient's care as well.[109] Still others are concerned that the incorporation of mental healthcare into physical care clinics will place too much emphasis on psychiatric medicine as opposed to talk therapy.[110] Not only would this not be a catch-all solution, but it would make it more difficult for poor people to access treatment as they may not be able to afford medication.[111]

Independent of the mhGAP, some developing countries have taken steps to create effective policy for mental healthcare. Thailand, for example, debuted a pilot program giving mental health training

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[103] Ibid.
[104] "mhGAP: Supporting Ebola Survivors in Guinea." *World Health Organization.* World health Organization. 2016.
[105] Ibid.
[106] Ibid.
[107] "Mainstreaming mental health in Ethiopia." *World Health Organization.* World health Organization. April 2016.
[108] Campbell C and Burgess R. "The role of communities in advancing the goals of the Movement for Global Mental Health." *Transcultural Psychiatry*. 49(3-4): 379-395. 2012.
[109] Ibid.
[110] Fernando, 2014.
[111] Ibid.

to doctors in rural clinics in the Kuanghai district and Ucanratchthani province.[112] Just one year after the training, reports showed that patients were being referred to psychiatric hospitals less frequently, were more likely to take advantage of outpatient care in their mental health, and were noticeably improving.[113] In response to these findings, the Thailand Ministry of Public Health expanded this program beyond its initial border and designated mental health care as one of the 11 elements of primary health care for Thailand.[114] More recently, Uganda unveiled a new national mental health policy in 2012.[115] This policy, like many others, emphasizes the importance of including mental healthcare in general healthcare policy and practice as well as increasing access to mental healthcare services.[116] The policy also stresses the importance of community involvement in mental health, listing as one of its key priority areas "strengthening community mobilization for involvement and participation."[117]

*Figure 4.* In Uganda, local programs train people to become mental health counselors.[118]

[112] World Health Organization. United Nations. *Mental Health Care in Developing Countries: a Critical Appraisal of Research Findings.* Geneva, Switzerland: WHO Document Production Services, 1984.
[113] Ibid.
[114] Ibid.
[115] Ssebunnya J, Kigozi F, and Ndyanabangi S. "Developing a National Mental Health Policy: A Case Study from Uganda." *PLOS Medicine*. October 2, 2012.
[116] Ibid.
[117] Ibid.
[118] Thrive Gulu. Via *The Commonwealth Fund.* February 2021. https://www.commonwealthfund.org/publications/2021/feb/making-it-easy-get-mental-health-care-examples-abroad.

Some of these new policies have come not from national governments, but from academic institutions. In 1977, the School of Medicine in Santiago, Chile created a program that trained general practitioners in mental healthcare, and incorporated mental healthcare into pre-existing clinics in the East Santiago area.[119] After the implementation of this program, researchers reported that fewer people in that area were being referred to psychiatric hospitals, presumably because they were able to address their mental health at home, under a doctor's supervision.[120] Unfortunately, despite the program's success, it was never expanded past the East Santiago area.[121]

[119] *Mental Health Care in Developing Countries: a Critical Appraisal of Research Findings* 1984.
[120] Ibid.
[121] Ibid.

## Possible Solutions

***Training Physicians in Mental Healthcare***

One way to easily improve mental health in developing countries is to train primary care physicians in basic mental healthcare. One of the reasons mental illness is so difficult to treat is because there are few trained psychiatrists, so treatment centers quickly become very centralized.[122] These centralized treatment centers are difficult to access for many people, and often overcrowded.[123] By equipping local doctors - especially ones in rural areas - with basic psychiatric knowledge, developing countries can ensure more resources for people suffering from mental illness.[124] These doctors can often address psychiatric issues before they reach a point at which hospitalization or other intense psychiatric care would be needed. For example, in China, rural doctors were given basic training on how to handle cases of epilepsy.[125] Because of this training, the population in those rural areas saw an enormous decrease in hospitalization for epilepsy cases without any other outside intervention.[126]

***Centralizing Mental Health Programs***

Another important step in addressing mental illness in developing countries is to incorporate mental health into national and international health programs. All countries should have a national health policy that includes some funding for mental health research and care as well as guidelines for how mental health should be treated.[127] Countries should avoid "vertical" healthcare programs, where mental healthcare is overseen by one area of the government and physical healthcare by another.[128] Beyond health care policy, mental healthcare should also be incorporated into disaster response efforts. First, it is important that humanitarian aid include some resources like counseling to treat people who might have been mentally impacted by the disaster. Second, distributers of

[122] *Gap Action Program*, 2008.
[123] Ibid.
[124] Jacob, 2001.
[125] *Gap Action Program*, 2008.
[126] Ibid.
[127] Ibid.
[128] Jacob, 2001.

humanitarian aid should ensure that that aid is accessible, as people with mental illnesses often cannot access humanitarian aid due to their condition.[129]

Countries should also make an effort to centralize centers of mental health research. While the centralization of treatment centers is problematic for a number of reasons, the centralization of research centers is extremely important.[130] Not only will this allow researchers to collaborate and share information more effectively, but it will also help countries promote mental illness research which is very important, especially in low- and middle-income countries that may lack larger research centers.[131]

National healthcare programs should also move away from the popular hospital-based method of treatment and more towards community care. As mentioned previously, patients in psychiatric hospitals can be the victims of human rights violations and can have their condition exacerbated—and not treated—by their hospitalization. Community care helps people avoid hospitalization by giving them the resources to manage their mental illness in their own home.[132] This can be accomplished in a number of ways: by creating outpatient resources for patients to avoid hospitalization, by creating more localized mental health care facilities, by involving family in the person's treatment so that they can recover at home, etc.

One example of a very successful community mental healthcare program can be seen in the modern Shanghai mental healthcare system, which was specifically created to reduce the city's dependency on psychiatric hospitals.[133] The system divides mental healthcare into 3 levels of organization: municipal, district and neighborhood.[134] This allowed the program to be community-based while still having some overarching structure on a larger scale.[135] The program focused on keeping patients at home for as long as possible, and relies on family members and neighbors to help the patient through their treatment.[136] Doctors are to appoint two "psychiatric care units" from the patient's

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[129] "Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group", 2010.
[130] *Mental Health Care in Developing Countries: a Critical Appraisal of Research Findings* 1984.
[131] Petersen et al, 2010.
[132] Jacob, 2001.
[133] *Mental Health Care in Developing Countries: A Critical Appraisal of Research Findings.* 1984.
[134] Ibid.
[135] Ibid.
[136] Ibid.

friends and family who are responsible for checking in with the patient periodically and offering support through the patient's treatment. The program also placed high emphasis on having the patient continue to serve as a member of the community, even creating programs for patients to return to work once they reached a certain level of wellness and continue their treatment while employed.[137] Through this community care program, Shanghai was able to dramatically reduce the number of people admitted to psychiatric hospitals and improve the rate of recovery for people with mental illnesses.[138]

***Taking Down the Stigma***

Furthermore, the **stigma** surrounding mental illness needs to be overcome so that mentally ill people can seek treatment without fear of ostracization. Making mental health more visible by encompassing it into general healthcare is one way to do this, as mentally ill patients will be able to use the same facilities as physically ill patients and will not have to visit specialized psychiatric hospitals.[139] Certain cultural changes can be made too. Educating community leaders like government officials, teachers and clergy on the nature of mental illness can improve the way mental illness is viewed in that community as these leaders can pass their viewpoint on to other community members.[140] Finally, national mental health policies should endeavor to recognize people suffering from mental illness as human beings and ensure that their agency is always being respected. For example, strategies should be put in place to equip these people with income-generating work, and advocacy programs should be established to help these people participate in local government and access public resources.[141] By validating the agency of mentally ill people, governments can set a precedent for their country of respecting these people and reducing their stigmatization.

[137] Ibid.
[138] Ibid.
[139] Javanmard Y, Atashi A, Hajebi A and Noorbala A. "Strategies to reduce the stigma toward people with mental illness in Iran: stakeholders' perspective." *BMC Psychiatry*. 17(17). 2017.
[140] Ibid.
[141] "Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group", 2010.

### *Scaling Up Existing Mental Health Programs*

In order to improve mental health in developing countries, it is important to make use of already existing programs in this area that have the potential to effectively address the issue. There are three ways to use these programs to create more comprehensive mental health solutions on a larger scale: horizontal integration, vertical integration and diversification.[142] Horizontal integration means that existing programs are expanded to include more people or cover a greater geographic area. For example, if a program is particularly successful in one city, a horizontal integration of that program might be done by starting an identical program in another city. Vertical integration means that existing programs are integrated into larger institutions. An example of vertical integration might be incorporating a successful rehabilitation program into the local hospital so that mentally ill patients who are released from the hospital can still have some sort of support system. Finally, diversification refers to adding new innovations to existing programs. For example, a program that has been successfully training doctors to treat mentally ill people might expand their program to also train nurses. Comprehensive solutions for improving mental health in developing countries might use one or all of these techniques, depending on the needs of the community and the nature of the program.

Scale-up strategies like this are important because most successful model projects never expand past their original location and are not implemented on a national scale.[143] In order to make use of the scale-up strategy, national and international bodies should actively seek out successful local projects that could be implemented on a larger scale.[144] These bodies should consider what sort of scale-up strategy would be most important and set a concrete timeline for when the scaling-up should occur.[145] They must also consider any obstacles toward scaling-up, secure funding and resources for this process and ensure the long-term sustainability of the project.[146] Nations should heavily consider which people should be appointed to make these sorts of decisions. Should successful projects be recognized by community leaders or people in higher seats of governments?

[142] Petersen et al, 2010.
[143] Jacob, 2001.
[144] *Gap Action Program*. 2008.
[145] Ibid.
[146] Ibid.

Should the funding for scaling-up strategies be secured from national funding or through WHO or another international body? The answers to these questions will vary from country to country.

One problem with scale-up strategies that nations must address is how to ensure that these programs will be successful once they are implemented in another location. Unrealistic timing constraints can mean that projects are established too early and fail to achieve the same results because they are unfinished.[147] At the same time, projects that take too long to be implemented might become obsolete as the needs of the community change by the time the project begins.[148] Cultural differences between locations can also impact the success of the program, and organizers may find that the program needs to be altered before it can become effective in that area.[149] For example, a study comparing German and Indian schizophrenia patients found that Indian patients respond better to a more authoritative psychiatrist while German patients prefer working with a psychiatrist will collaborate with the patient to create coping strategies.[150] So, if a successful program in Germany was to be implemented in India, changes would have to be made in the patient-psychiatrist dynamic of that program in order to optimize its efficacy.

### *Integrating Local and Cultural Considerations*

Finally, as delegates begin creating solutions to diminish the burden of mental illness in developing countries, significant thought should be put towards the merits of localized responses versus international ones. As members of an international body like the World Health Organization, it can be tempting to implement these solutions entirely on the international scale since we have that capability. However, delegates should consider the impact that culture has on the way mental illness is manifested in different areas and the facts that different communities will have different mental health needs. These needs may even change over time. Some autonomy should be given towards individual nations and even individual communities to help them implement a mental health strategy that is appropriate for them. Delegates should also remember that change happens

[147] Petersen et al, 2010.
[148] Opaku, 2014.
[149] Petersen et al, 2010.
[150] Viswanath B and Chaturvedi S. "Cultural Aspects of Major Mental Disorders: A Critical Review from an Indian Perspective." *Indian Journal of Psychiatric Medicine*. 34(4):306-312. 2012.

gradually. Countries, especially those with very few resources for people with mental illnesses now, must focus on achieving realistic goals before approaching broader, idealistic ones.

# Bloc Positions

***Low-Income Countries: Burundi, Haiti, Niger, Rwanda, Sudan, Tanzania, Zimbabwe***

These countries will be most reliant on international aid to address mental illness within their borders. Mental health is likely not yet a high priority in their national healthcare scheme, but still a large problem for their citizens. These countries will want to focus on smaller, more local solutions and will likely advocate strongly for international support in securing both successful projects and sufficient funding.

***Lower-Middle Income Countries: Djibouti, Egypt, Guatemala, Honduras, India, Indonesia, Nicaragua, Pakistan, Syrian Arab Republic, Vietnam***

Like the low-income countries, these countries likely have not adopted mental health into their national healthcare and may not prioritize it very highly. Unlike the low-income countries, however, these countries may have the resources - both financial and governmental - to begin addressing the issue themselves. While still advocating for support from the international community, these countries will not be quite so reliant on international aid and may in fact prefer to implement their own programs rather than adopting programs from external sources.

***Upper-Middle Income Countries: Argentina, Brazil, China, Jamaica, Libya, Russian Federation, South Africa, Thailand, Turkey***

While these countries may not prioritize mental illness as highly as is necessary in their national healthcare scheme, efforts have been made to improve mental healthcare. These countries will want to focus on more broad, sustainable improvements than fast-acting local ones. These countries may also be overly reliant on psychiatric hospitals and be in favor of programs that would allow them to adopt more outpatient treatments. These countries will likely require little to no financial assistance from other countries or from international bodies.

***High Income Countries: Australia, Belgium, Canada, Chile, Croatia, France, Germany, Greece, Israel, Japan, Qatar, Saudi Arabia, Spain, Switzerland, United Kingdom, United States***

These countries likely have the least severe burden of mental illness. While some clinics in these countries may still adhere to outdated or ineffective forms of treatment, there are likely many more options for people suffering from mental illness. These countries may still not be funding mental healthcare adequately but certainly have the resources to do so on their own. In fact, these countries may be willing to supply assistance - financial or otherwise - to lower-income countries looking to adopt more comprehensive mental healthcare. These countries will likely be most interested in solutions that systematically change the way we view and treat mental illness as an international community and defining international standards for mental healthcare.

# Glossary

**Anorexia:** An eating disorder characterized by an aversion to eating. The condition is often associated with body dysmorphia (a distorted view of one's own appearance) and a need for control.

**Epidemiology:** The pattern of where a disease occurs in a population and who it affects.

**HIV/AIDS:** Human immunodeficiency virus (HIV) is a retrovirus that targets the immune system and can lead to a condition called acquired immunodeficiency syndrome (AIDS), in which the immune system function is severely reduced, and the patient is vulnerable to a number of infections and cancers that a healthy person would otherwise not be as vulnerable to.

**Humorism:** An ancient theory of medicine that explained health and disease as a function of four "humors", blood, yellow bile, black bile, and phlegm, according to their relative levels in the body. Diseases were thought to be caused by an excess or deficiency of one of these humors and health could be improved by restoring balance, often through bleeding or inducing vomiting.

**Intervention:** Action taken to improve a situation. National interventions in mental health may take the form of the development of new programs, removing barriers to accessing mental healthcare and taking action to more closely monitor current mental health treatments.

**Patent:** A government authority granting the right of ownership over a certain invention for a set amount of time that allows the owner to prevent others from manufacturing or selling that invention until the patent expires.

**Pilot program:** A new program that is debuted on a small scale or in a limited timeframe with intention of extending the program if it is successful.

**Post-Traumatic Stress Disorder (PTSD):** A condition of physical and mental distress following a traumatic event, repeated trauma, or long-term exposure to secondhand trauma. The disorder has a number of symptoms that sufferers may exhibit including flashbacks, anxiety, changes in eating habits and intense mood swings.

**Stigma:** A set of negative beliefs surrounding a certain condition that can result in societal ostracization for individuals displaying this condition.

**Trepanation:** An outdated medical practice of drilling through people's heads and removing large parts of the skull, but not enough to kill the person. Historically, trepanation has been used to treat spiritual possessions, mental illness, headaches, and a number of other conditions. A similar, though much safer, procedure is sometimes used now to relieve pressure on the brain following intense internal bleeding that may damage the brain.

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