A Global Community of Neglect: The Prevalence of Mental Illness in Developing

Communities

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Abstract

This thesis examines the current inefficiencies in approaches towards global mental healthcare. The focus of this research is placed on the global community and their failure to adequately alleviate the suffering of mentally ill individuals. Multinational organizations, such as the World Health Organization, haven't done enough to hold member states accountable for the lack of sufficient mental health interventions. I argue that there is global neglect subjected to the area of mental health and this has in effect catapulted a series of problematic conditions present in many developing communities. I also showcase the crucial importance in prioritizing mental health in a development context. I highlight the essential and moral obligation in undertaking mental illness interventions, but I also highlight the various economic benefits as well. To successfully feature the necessity of mental health preventative and treatment measures, I outline various case studies that suggest that mental illness is incredibly neglected and that underline the ineffective approaches currently at work. In highlighting the gap between communities on the ground and various stakeholders, I go into explaining primary care approaches that would mitigate the feeble mechanisms in place. By breaking down the global healthcare model, I delve into prioritizing localized and indigenized approaches, as well as highlighting the partiality in pharmaceutical tactics. Overall, the systematic processes currently at work go against the well-being of mentally ill individuals in the developing world. Lastly, in my recommendations I suggest the need for an adequately funded, impartial body of researchers to investigate and find appropriate mental healthcare methods, due to the lacking amount of research current in place throughout the developing world.

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Table of Contents

Introduction

There are many intangible workings of our world that we all ponder and think about, but we don't really delve into. I have noticed that there is a tendency to shield our true feelings from one another out of fear, and an unwillingness to invest in what we consider 'unimportant' human interactions. For instance, someone might be experiencing a bad day and because they have projected that unto us we internalize it without taking a step back and trying to understand why they would act in such a way. Perhaps they are having a bad day and you just happened to cross paths with them at an unfortunate moment.

Ultimately, it all comes down to the question of why should one even care? Honestly, why should I care about someone and how their day went? What does the cashier at my local grocery store mean to me? Why is forcing a smile necessary? Why should I hold the door for the individual behind me? Why does the suffering of people in Rwanda matter to me? Why does a child labourer's distress bother me? I believe that fundamentally we need to care because being sensitive to the human condition is a fundamental part of our own existence. We are not robots that are programmed to work 9-5pm and simply rest up for the next day, rather we are people with emotions and feelings. Happiness is fundamentally what we all strive for, therefore we all owe it to each other

and ourselves, to take good care. It is as simple as that. As children, we are introduced into the world wanting to embrace everything. We look at the world with curiosity. If you ever look into a child's eyes the first thing you notice is how receptive they are of your every move, and how their facial expressions tend to mimic the aura that you project. Children also have a tendency to see the good in everyone and we are fascinated by this innocence, which is why we do whatever we can to not disturb their peace. Yet as children grow older the euphoria that is evidently present tends to slowly dwindle. Life hits us with bigger blows over time and that becomes our world. Some of us unfortunately become engulfed and feel like we have lost control of the steering wheel and overtime we lose hope and just live without really living. As one gets older, their life is essentially determined by the privilege they are bestowed. Therefore, as someone who is fascinated by the human experience I want to understand people's emotional suffering. That is precisely why I have pursued this research, because I see the importance in shedding light on a fundamental component of the human experience...the psyche.

In having this outlook, I am most interested in the conditions of mentally unwell individuals within developing communities. In developing and developed communities, mental health is on the back-burner. Understandably, there are other

important national concerns that are prioritized over mental health, but unfortunately communities suffer greatly because of this. Mental well-being is a critical component of every individuals' life, therefore shouldn't it be on the front-burner in most organizational agendas concerning health? Seemingly so, mental health is completely neglected and most especially in communities that need mental health interventions the most. The developing communities in which there are conditions of inequality, poverty, political strife, environmental catastrophes, etc., are the communities in which mental illness programming needs to be instated. The countries in which community members experience long-term exposure to trauma and despair happen to be the countries with the most amounts of mental health issues. Knowing that there is global neglect subjected to the area of mental health and how this has in effect catapulted a series of problematic conditions present in many developing communities, I will be arguing that there is crucial importance in prioritizing mental health in a development context.

Defining Health

The term 'health' is challenging to define because there is no fixed definition associated with it. Health tends to be linked to any mention of disease and the absence of disease

automatically determines an individual to be healthy. At first glance, this definition of health can be an accurate portrayal, but in reality, the simplicity of it can be quite limiting. The definition associated with health in the Oxford dictionary is: "the state of being free from illness or injury" (Oxford Dictionary, oxforddictionaries.com). In reference to what I mentioned earlier, this definition of health is also quite vague and limiting at the same time. In reading that definition, one may be under the impression that health amounts solely to an elimination of all physically apparent ailments, which can cause one to have a constricted and ineffective approach to solving any such issues that do not fall within that overarching definition of health. This is precisely why there is a need for development workers that hail from disciplines like anthropology, international development, and the like to have their say and input into defining health. The responsibility in the maintenance of healthy individuals is not solely a scientific domain, rather it is a collaboration of various understandings to formulate a holistic approach towards it. As stated by Harald Brussow in his article *What is Health* (2013), "economists and sociologists have a greater interest in the health of a population when focusing on the productivity and social 'functioning' of people" (2013, p.344). Health is pivotal in understanding development work, therefore it must be studied and

researched in this discipline. Due to the nature of development work, health research does take on a global component, therefore it is necessary to understand health in an international context.

In regard to a satisfactory definition of health, I find that the World Health Organization's (WHO) definition most aligns with that holistic understanding of health. The general WHO definition of health is defined as being, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Constitution of the World Health Organization). WHO's approach highlights that there is more to health than just the riddance of illness or disease, and rather mental and social well-being are just as pivotal to one's health.

Health and Socioeconomic Development

The intersection between health and development produces two main focal points: economics (efficiency) and livelihood (equity). When it comes to health, efficiency and equity are correlated in a sense that cost-effective health tends to be the most equitable. And the most equitable forms of health provided — public and accessible — tend to be the most efficient. To outline this, I'll borrow from Musgrove's point in, *Public Spending on Health Care: How are Different Criteria Related?* (1999), "and since the poor are more likely to be malnourished, and since

malnutrition greatly increases the risk of death from measles, immunizing the poor prevents even more health loss than among the non-poor"(1999, p.212). Musgrove's point both highlights the social duty that development workers have in prioritizing the healthiness of all, as well as the necessity of it economically. Interventions in attempting to tackle dire diseases can be costlier, in comparison to preventative methods, such as vaccinations, that target diseases early on in an individual's life.

This brings me to the point that there is a definite correlation between healthcare improvements globally, and international economic growth. The overall health and wellbeing of a population, positively impacts the productivity of a nation, which enables a state to reinstate finances gained from health improvements towards other sectors.

Investment in health is investment in human capital, according to Emile Tompa (2002), in his article *The Impact of Health on Productivity: Empirical Evidence and Policy Implications* (2002, p.182). This means that labour productivity, which is essentially made up of human capital, is dependent on the proper provisions of adequate health services to workers.

Now on a more aggregate level, the economic development of a society is conditional on the healthiness of its citizens. As catalogued in Emile Tompa's, *The Impact of Health on*

Productivity: Empirical Evidence and Policy Implications (2002),
the productivity of a nation is very dependent on the quality of
health being acquired by its citizens. Generally, a healthy
worker is more likely to not miss work days and contribute
greater amounts of time and effort to their occupation. A
healthy individual is also more likely to contribute to a
positive work environment, which increases the overall mental
wellbeing of individuals at work, therefore making workers more
motivated in contributing to the labour productivity of a state.
A healthy population also increases the life expectancy of
workers, therefore yielding long-term workers that will invest
in their retirement, "resulting in a greater accumulation of
physical capital"(2002, p.4).

At the individual level, healthcare is especially essential
to early childhood development. According to a summary titled,
Investing in Health for Economic Development, published by the
World Health Organization (2004), children that receive
insufficient nutritional care become less likely to perform well
in school which limits their chances of going out into the work
force and contributing to their individual financial security
(2004, p.18). Growing up in an unhealthy environment that lacks
proper nutritional support tends to limit a child's cognitive
abilities, which hinders their educational attainment and limits
their skills to become a fully capable adult. The likelihood of

this child getting a decent education diminishes, therefore enabling the cycle of poverty to be sustained. Children who are not exposed to adequate healthcare tend to grow up lacking the proper means to provide sufficient healthcare to their own offspring, which preserves this cycle of continuous poverty for the lower economic sector. For instance, in the case of Mexico's pro-market reforms, which failed to address healthcare and reemphasized the market economy, there was an imposition of the poverty trap for the lower-class sector which made room for greater inequality. Pro-market reforms were expected to increase human capital production and promote better economic outcomes for the lower-class sector, but clearly failed (2004, p.19). This limited the number of individuals partaking in the national workforce and mainly upper and middle-class members of society became the main contributors to human capital. Therefore, inequality persisted and there was a greater divide between the upper and lower-class sectors. This highlights that inefficiencies in safeguarding health, at the top level, negatively impact individuals at the bottom level, which hinders society as a whole. This loop becomes consistently impactful.

Breaking Down Mental Health

Following in the footsteps of Nicola Khan (2017) in her book, *Mental Disorder*, this research will use the terms disorder and

illness as opposed to disease or sickness when referring to mental dysfunctionality because the terms disease and sickness are seen more so as a medical and professional category to distinguish a collection of symptoms, whereas the terms disorder and illness are seen as a relation one has to feeling unwell. All references to mental illnesses/disorders, that are mentioned in this document, are encompassing mainly of mood and anxiety disorders.

One very necessary mention is the elimination of a focus towards a specific "truth" when it comes to the underlining reasoning behind mental illness. Many in the science community tend to relay mental illnesses to solely being a biological problem and this has increasingly become a dominant view. According to Khan (2017), "the 'brain-disease model' is the dominant approach in US psychiatry" (2017, p.XVI). The 'brain-disease model' emphasizes that mental illness is a symptomatic condition of neurological malfunctions and fails to adequately recognize other dominant factors in the development of mental illness. On the other spectrum, there are those that are vocal about mental illness solely being an appendage of a larger societal issue. Besides this theory being one-sided and polarizing, it also neglects medical understandings that may explain mental illness. Serotonin deficiencies, paralyzing anxiety, and depression that causes one to be bedridden are not

simply constructs, rather they're complex symptoms of a crisis that could be linked to environmental, biological, social and economic conditions.

A project initiated by the UK government known as, the Foresight Project on Mental Capital and Wellbeing, highlighted that there are two types of mental development. They are:

"**Mental capital** encompasses both cognitive and emotional resources. It includes people's cognitive ability; their flexibility and efficiency at learning; and their 'emotional intelligence', or social skills and resilience in the face of stress" (Beddington, 2008, p.1057).

"**Mental well-being**, on the other hand, is a dynamic state that refers to individuals' ability to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community" (Beddington, 2008, p.1057).

In this paper, there will be a focus on the latter, mental well-being, with some mention of mental capital — to highlight the economics of mental illness — in reference to the overarching idea of mental well-being.

Mental health is integral to an individual's overall wellbeing. Globally, mental health has become increasingly neglected even though there is a larger portion of the world population that suffer from mental health issues. According to Ngui et al, in their article, *Mental Disorders, Health Inequalities and Ethics: A Global Perspective* (2010), about 30% of the world population suffers from mental health illness with only one-third receiving treatment (2010, p.235). With that being said, mental health is highly neglected in the international community. The needs of mentally ill individuals are either inadequately addressed or not prioritized. Mental health inequalities are perpetuated due to dissonance between the socioeconomic conditions of mentally healthy individuals and the socioeconomic conditions of mentally ill individuals. Impoverished individuals are far more likely to develop mental illness, and the health concerns of those situated in the lower economic bracket tend to be neglected. Therefore, private or sufficiently funded health facilities are inclined to address other health concerns that do not pertain to mental health because the stream of patients that access their facilities tend to be of the middle or upper-class sector. Poorly funded health facilities are less likely to have functional mental health resources. This is due to a lack of advocacy for marginalized communities that disproportionately experience mental health. As

outlined by Ngui et al, "in many developing nations with mental health policies, scarce resources and infrastructure, ineffective advocacy and the lack of political will limits effective mental health legislations and interventions"(2010, p.237).

There is also a growing amount of stigmatization against individuals that are mentally unhealthy. The stigma that surrounds mental illness produces restrictions for people who identify as being mentally unhealthy. Due to the limited amounts of funding tailored towards mental health programs within developing countries, individuals that discuss their mental illness openly become subjected to stigmatization by their communities and left to cope with no resources available to them. Therefore, this results in an isolation from social gatherings, schools, work…etc. Ngui et al (2010), also addresses the deterrence of healthcare students from wanting to pursue a field in mental health/psychiatry. Due to the stigma attached to anything concerning mental health, health professionals are more likely to disentangle themselves from trying to delve into this segment of health. The stigma associated with mental health originates from traditional understandings that mental illness is a reflection of being under the influence of demons or spirits. As outlined by Ngui et al, "limited knowledge of the causes, symptoms and treatment of mental illness often leads to

common but erroneous beliefs that these conditions are caused by individuals themselves or by supernatural forces, possession by evil spirits, curse or punishment following the individual's family or is part of family lineage"(2010, p.239). Therefore, due to this association, individuals that experience mental illness are less likely to be forthcoming and open about their experiences.

In many parts of the developing world, individuals suffer from unemployment, poverty and exclusion. The state of governments in these developing countries are usually plagued with corruption. Due to this corruption, they are unresponsive to their citizens and many are left to fend for themselves. Communities that fail to address mental health wellbeing and/or provide inadequate support, have a tendency to increase risk of developing a host of consequential side effects in the long-term. These side effects tend to negatively impact the community as a whole as well as the individual at the socio-economic level. As outlined in the article, *Mental Disorders, Health Inequalities and Ethics: A Global Perspective* (2010), individuals that undergo mental illness are more likely to be unemployed therefore influencing the productivity levels within a country. If a significant amount of the population that experiences mental illness do not acquire suitable resources in treatment, productivity levels in a country could experience a

downturn. In the case of Kenya for instance, the economic loss experienced due to a lack of support for mental disorders, accounted to being $13 million. Economic growth is not only limited to the number of workers in an industry, but also due to the inhibition of creativity and innovation. Workers who deal with mental illness may harbour ground-breaking ideas, but due to the absence of support for their health, they may not have the opportunity to showcase their talents.

Literature Review

Health Inequalities

The locale in which an individual resides in can be a determinant of one's health outcome. Disadvantaged populations within developing or developed countries generally have a higher mortality rate. Growing research highlights the impact poverty has on the health outcomes of populations. Developed countries such as Finland, Iceland, and Japan tend to have lower child mortality rates in comparison to developing countries such as Sierra Leone, Iraq, and Zimbabwe. Even within countries, socioeconomic disparities can create various levels of health inequalities. For instance, within the United States there is a 20-year mortality difference between advantaged and disadvantaged populations (Marmot, 2005, p.1099). From 1970 to 2002, mortality rates have risen in Africa and Eastern Europe, but have decreased everywhere else in the world (Marmot, 2005, p.1100). A man in Zimbabwe has an 82.1% chance of dying in comparison to a man living in Sweden who has an 8.3% probability of dying (Marmot, 2005, p.1100). In recognizing these discrepancies there needs to be a reflection of how an individual's socioeconomic situation determines their health condition.

The social determinants of health, as Marmot terms it in his article analyzing WHO's Commission on *Social Determinants of*

Health (2005), are the underlying socio-economic conditions that perpetuate health inequities. Social inequalities are exacerbated depending on the living condition of an individual. Where one resides is a major factor in determining one's health condition. With 1 billion people living in slums and poor urban settings, the gross amount of people suffering from non-communicable diseases has risen exponentially. In another article by Marmot, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (2008), Marmot and other authors highlight the impact urban effluence has on the wellbeing of inhabitants.

Connections Between Mental Health and Poverty

Mental ill health is the inability for an individual to lead a fulfilling life. Poor mental health is brought on by internal and external factors. The internal factors include, "a lack of emotional resilience, poor self-esteem and social status, feeling trapped and helpless, and problems associated with sexuality or sexual orientation, isolation and poor integration" (Bhugra, 2013, p.3). External factors are, "poor social conditions (housing, poverty, unemployment), discrimination or abuse, cultural conflict, stigma and poor autonomy" (Bhugra, 2013, p.3). A mentally healthy individual will have a strong sense of who they are, will be more likely to have positive

relationships, will feel accomplished and be spiritually, emotionally and intellectually sufficient. Also, how one deals with their stresses in times of adversity is also very important. Stresses that arise from socioeconomic pressures, discrimination, physical ailment and much more can be triggers of poor mental health.

When it comes to the relationship between individual income levels and mental health, Kleinman and Patel, do not explicitly say whether or not there is a direct correlation, but they do hint at it. In the article, *Poverty and Common Mental Disorders in Developing Countries* (2003), Kleinman and Patel, take into account factors such as poor housing to outline an adequate association between mental health levels and poor housing conditions. Poor housing or living conditions can be a direct result of poverty, and because Kleinman and Patel outline the association between poor housing conditions and mental illness, the assumption can be made that there is a link between poverty and mental health.

Kleinman and Patel (2003) showcase how conditions of continual insecurity can heighten feelings of anxiety and depression. When individuals experience an economic downturn in their life and feel as though they are conditioned to unemployment or low-wage situations, this can result in feelings of hopelessness. For instance, the authors outline how the

workings of globalization can have detrimental effects on rural farmers which can motivate a dramatic move to urban locations. This complete change in lifestyle can intensity feelings of hopelessness and spiral a mental health crisis (2003). The thought that nothing can be done about one's financial condition and the feeling that individuals have little to no control over their livelihood, can spur desperateness.

Experiences of financial insecurity can be a form of shame for individuals. The stigma attached to financial insecurity is daunting and problematic for mental health. According to the authors, many individuals have been forced to borrow money from community members and work in stigmatized positions, resulting in these individuals being negatively branded by community members, due to their financial status. The stigmatization of individuals can exacerbate a feeling of incompetence and can demotivate individuals from seeking out alternatives to alleviate their financial distress. Through this process, mental health is not only a symptom of financial insecurity, but it also becomes a designer of it.

Kleinman and Patel also touch upon the effects of social change on mental health and how, "there is evidence that social factors, in particular life-threatening events, violence and the lack of social support, play an important role in the etiology of common mental disorders"(2003, p.611). This demonstrates that

a lack of satisfactory social needs jeopardizes the mental state of individuals. For instance, a push towards urbanization catapults a drastic change in social interactions. Individuals that were once familiar with community based social exchanges have to undergo more isolating situations that are completely bereft of communal support.

As the authors point out, low levels of education can directly impact an individual's social status which has an effect on their mental health. Poor education is associated with the relegation of individuals to lower class levels within a society, which can cause discrimination and a feeling of uselessness. Malnutrition, which stems from low income levels, can hinder educational attainment, outlining how poverty can become a contributing cause of mental health problems. Inaccessibility of primary educational institutions, due to poverty, can be a source of mental health disorders in adulthood. Kleinman and Patel highlight how, "the social consequences of poor education are obvious: lack of education represents a diminished opportunity for persons to access resources to improve their situation and low levels of education have been implicated as a risk factor for dementia"(2003, p.611). This highlights that stimulation in the brain from engaging in higher levels of education, protects individuals from "cognitive impairment" (2003, p.611).

Kleinman and Patel also highlight the significant toll women experience in urban settings. It has been proven that women tend to be under a great deal more stress in contrast with men when experiencing difficulties. Due to patriarchal constructs, women are more likely to have a harder time finding a job in urban areas. They also are socially pressured into carrying on the double burden of tending to their children as well as attempting to participate in the working sector. Therefore, women are more prone to the onset of mental disorders because they take on more responsibilities within the household as well as outside the home. Srivastava, in her article *Urbanization and Mental Health* (2009), emphasizes the effects that socioeconomic stresses have on women in particular. She addresses this by saying, "women are particularly vulnerable and they often disproportionately bear the burden of changes associated with urbanization"(2009, p.75). Women tend to take on the brunt of stresses within the family structure in many communities, due to the conditionality set on them to take on multiple roles within their household. Women are also faced with the onset of having to challenge the predominate patriarchal dogma within their workforce, as well as adapt to their new role within the family.

Kleinman and Patel (2003), also address the effects poor physical health can have on one's overall mental health. The

authors state that, "there is evidence demonstrating the comorbidity between physical illness and common mental disorders, and this association may partly account for the association between poverty and mental disorders"(2003, p.612). Prolonged poor health tends to originate from poverty and the inability to pay for health care. An increase in physical healthcare costs, tends to advance mental health issues. This is due to the stress associated with feeling like one doesn't have the capacity to change their situation.

After completing their study, Kleinman and Patel (2003) found that there was a great deal of association between poverty and mental health disorders. The authors concluded their findings by saying, "in any event, it is more likely that poverty and common mental disorders interact with one another in setting up, in vulnerable individuals, a vicious cycle of poverty and mental illness"(2003, p.612). There are many complexities associated with mental health and poverty, and a great deal of research still needs to be done to solidify this correlation.

According to Srivastava, in the article, *Urbanization and Mental Health* (2009), the world's urban cities are increasingly becoming overpopulated, especially in developing societies. Figures projected by the World Health Organization highlight the possibility that more people will be living in urban cities than rural communities. Urban areas are becoming attractive options

due to the possibility of increased job opportunities and the possibility of an influx in business creation prospects. Rural inhabitants are funneling into cities in hopes of alleviating their financial distress. The ways in which cities get defined rely predominantly on the jurisdictional definition of what constitutes a city.

According to Marsella, in the article *Urbanization, Mental Health, and Social Deviancy* (1998), urban areas have historically been romanticized as being havens of progress and innovation. As the author says,

> "urban life offers residents a broader and more varied
> mix of intellectual and cultural stimulation, economic
> opportunity, and personal choice in pursuing various
> social roles and relations and moral options – including
> seemingly endless options for money, opportunity,
> freedom, excitement, diversity, intellectual stimulation,
> improved public utilities...[etc]" (1998, p.624).

This gleaming perspective on urban areas has been counteracted overtime with intellectuals like Rousseau, who have termed urban hubs as being synonymous with self-destruction and spaces that facilitate greediness. Urbanization is an interconnected medium of various factors that have come together to shape the social conditions of people residing in urban dwellings. As defined by

Marsella, "urbanization is the dynamic process and product that emerges from the complex interaction of population, spatial-geographical, historical, cultural, economic, and political forces for the socioenvironmental formation with resulting patterns of psychosocial adjustment and adaptation" (1998, p.625). This definition by Marsella, identifies the impact that the process of urbanization has on the psyche of an individual.

In the article, *Urbanization and Mental Health in Developing Countries* (1994), Harpham delves into mental health disorders and how it is becoming increasingly prevalent in urban inhabitants. The reality is that due to a rapid flow of migration from rural areas, urban areas are producing inhabitants with mental health disorders. As Harpham says, urbanization is associated with many health problems. The lack of medical support for individuals experiencing a host of mental illnesses, proves that there is an absence of awareness surrounding mental health. As Harpham says, "despite the extent and urgency of the problem, mental illness continues to be assigned low priority"(1994, p.234). The inefficiencies associated with trying to diagnose individuals with mental health problems showcases the lack of investments by practitioners in attempting to tackle the health crisis.

According to Harpham (1994), there has historically been a great deal of interest on the impact urbanization has on mental

health. For instance, in the 1940's Louis Wirth recognized the social and mental influences city life has on individuals. As Harpham says, "Louis Wirth in the 40's contended that urbanization led to extensive differentiation and separation among occupational, familial, recreational and institutional aspects of life, thus preventing a normative consensus at the community level"(1994, p.234). In the 1950's Leighton proposed the notion that mental health disorders were predominately a result of family disintegration, "limited social networks, high levels of hostility and similar traits"(1994, p.234). Leighton acknowledged that urban dwellings stimulated mental disorders, but he also believed that the root causes of mental disorders stemmed from rapid change in lifestyles, poverty, and cultural confusion. It was not until Marsella, in the 1970's, that anyone conflated urbanization and mental disorders. According to Harpham, Marsella argued that urban issues such as, "housing, work, marriage, child rearing, security and other urban problems", in combination with limited resources, were the sources of mental health disorders (1994, p.234).

   Mental health disorders in developing countries continue to get less visibility in the medical field. Infectious diseases, especially at the epidemiological level, are greatly prioritized in comparison. Practitioners are more inclined to treat mental

disorders as biological or chemical dispossessions within the brain. This makes the treatment of mental health disorders minimal and straightforward, and promotes the field of psychiatry to solely be within the realm of science.

According to the authors of, *Measuring Mental Illness Stigma* (2004), stigma can be conceptualized under two theoretical frameworks. The first theoretical framework was conceived by Goffman who defines stigma as being, "a relationship between attribute and stereotype" (2004, p.512). The second theoretical framework can be categorized under six umbrella concepts. The first is concealability, which is the capability for a stigma to be concealed sufficiently — the greater chance the stigma can be concealed the less likely it is to be as prominent enough to be subjected to stereotyping (2004, p.512). The second is course, which is associated with the ability for a stigma to be, "reversible over time, with irreversible conditions tending to elicit more negative attitudes from others"(2004, p.512). The third is disruptiveness, which is the notion that the identification of a certain attribute may cause a break in communication between people. The fourth being aesthetics, is associated with the appearance of an individual and how that spurs a certain reaction from people who perceive that trait. The fifth is origin, which is the source in which any form of stigma develops

from. And finally, peril refers to feelings of fear and anxiety that emerge from identifying an individual and associating them with a certain quality. Link et al (2004) disassociate from the notion that stigma is a direct result of the inability of people to connect with their surroundings. Rather the authors adhere to the idea that stigma can be tackled by looking at the discriminatory nuances that develop from it. Link et al acknowledge the manifold aspects that come together to stereotype an individual and cast them under a category. These various components come together under the context of power and the group of people that have access to that power.

   The authors of, *Measuring Mental Illness Stigma* (2004) acknowledge the stigma that is associated with mental illness and how that contributes to the withdrawal and isolation of individuals that experience mental health issues. The undesirability of mental illness leads to the casting of individuals that have mental disorders as being incapable of participating with the rest of society. Therefore, mental illness has been fundamentally ingrained as being a disadvantaged disorder. This perpetuates the stigma attached to mental illness, which promotes individuals to not speak up about the illness, therefore reducing the momentum behind trying to garner attention around this very important issue.

The Definers of Mental Health

There must be deep consideration into what we term as mental illness due to the political biases that may be behind such a definition. As with many terms, there are colonial remnants that may influence our understanding of mental illness. Johnathan Metzl, in *The Protest Psychosis* (2011), highlights how during the 60s there was a growing trend in associating schizophrenia with the civil rights movement. Through the attempt of delegitimizing activists associated with various civil rights protests, medical ad campaigns depicted "angry black men [with] African tribal symbols" parallel with being 'insane' (Khan, 2017, p.8). It was as though schizophrenia was depicted as being a 'black problem'.

     This sweeping generalization of what is termed as mental illness also needs to be contested. Looking at Ruth Benedict's thoughts, in her article *Anthropology and the Abnormal* (1934), she showcases how there are differences in people's perceptions of abnormal depending on the culture they adhere to. "What is 'abnormal' in one culture may be viewed as quite 'normal' in another culture" (Khan, 2017, p.1). Benedict refers to abnormality as being a remnant of a particular cultural expectation that an individual cannot adhere to. According to Benedict, the circumstance of the individual's culture matters and therefore depending on their culture one may be perceived as being

abnormal or normal. Khan (2017) points out that, "for Benedict, the actual type of abnormality is not a problem. Instead it is the individual's exclusion from participation in recognized patterns of society that makes abnormality a problem"(2017, p.2). To transmit her point, Benedict uses the evident patriarchy in the Western world as an example of something other cultures may decipher as being abnormal. Many distorted figures in the West hold positions of authority and dominance and yet the hegemonic view is that they are 'normal' and perhaps just expressive and honest. Whereas in many other cultures the type of behaviour displayed by these public figures may be seen as sufficient enough to discredit them.

Benedict (1934) makes it clear that being 'abnormal' isn't the issue, rather the isolation that transpires from that abnormality is a cause for concern. Taking all this into consideration, Benedict does realize that there are individuals that have crippling mental disorders that may inhibit them from adequately functioning in society. As much as Benedict's understanding of cultural influences on mental health is reasonable, it still fails to address systemic pressures that may intensify mental illness as well as biological constraints that may impair individuals.

The way language is utilized around mental illness can also have lasting effects on how an individual struggling with their

mental health, advances overtime. As Khan (2017) highlights, "indeed, professionalized languages about the duration of mental disorder have profound effects on mental illness outcomes and on ideas of recovery. Anthropologists, for example, have leveled strong critiques at the notion of chronicity, which is, "the idea of lifelong disorder, and ways that dependencies on therapeutic and pharmaceutical regimes can transform acute conditions or illness into chronic lifelong experiences of disorder"(2017, p.19). This highlights how perhaps the dominant Western understandings of certain mental illnesses, may result in the creation of harmful diagnoses.

All these understandings are variations in discourse surrounding mental illness. Despite all these references, in keeping in line with the research, the 'definers' of global mental illness that have the most impact in our current understandings, happen to be multinational organizations. Firstly, there needs to be an understanding of the origination of approaches towards global mental health. Global Mental Health (GMH) was first initiated in hopes of addressing mental health neglect in low and middle-income countries. Ideas surrounding GMH have been used in such a way that creates a hierarchy between the North and South, and can cause health professionals to approach diagnoses with Western constructs. The over emphasis on psychiatric prescriptions as a means of addressing mental

illness has been a primary medical model used in GMH. As Khan (2017) highlights, "vast profit-making opportunities for pharmaceutical companies result in 'disease mongering', over diagnosis, unnecessary tests and treatments, and wasted resource" (2017, p.70). This dissemination of one primary approach towards GMH is a cause for concern and definitely prompts one to think about who's 'truth' should be prioritized.

There has been this growing tendency to approach mental health in strictly cost-effective ways that go counter to culturally specific approaches or as said in Sara Cooper's (2016) article, *Global Mental Health and Its Critics: Moving Beyond the Impasse*, "the culturally determined nature of mental illness, and as such is leading to inappropriate diagnoses, locally incongruent solutions and the marginalization of 'traditional' systems of mental health and healing" (2016, p.355).

As outlined in the World Health Organization's Mental Health Action Plan (MHAP), upkeep of the mental health condition and state of an individual is paramount to a healthy society and this can be attained by catering to an individual's socioeconomic needs. MHAP (2010) was first adopted as a resolution and then expanded into this comprehensive strategy. In adopting this plan, the WHO recognizes that some individuals are more vulnerable when it comes to experiencing mental health issues.

For instance, WHO singles out people with chronic health issues, and individuals that are experiencing poverty. Staggering figures that are brought up by the MHAP (2010) include the global economic impact of mental disorders, which will amount to USD 16.3 million (2010, p.8).

Despite the advances in publishing the MHAP, WHO needs to recognize that mental health issues are a fundamental obstacle to achieving any development goals, and neglect of addressing this pivotal issue could result in greater problems for any community. According to the MHAP, between 76-85% of people living in low and middle-income communities do not receive adequate assistance for mental health issues. And in high-income countries the percentage is also relatively high 35-50% (2010, p.8). Also, the amount of money catered to mental health is only USD 2 per person in high-income countries and 0.25 per person in low-income countries, with 67% of that allocated to "stand-alone" hospitals.

The implementation of the MHAP has been fundamental in the overall shift towards prioritizing mental health. That being said, there needs to be a larger shift that outlines how essential mental health is in regard to the overall health of a large community.

Data, Data, Data

As outlined in the World Health Organization's (WHO) publication, *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (2010), mental illness in developing communities produces vulnerable people. Individuals with mental illness should be of great concern to stakeholders and development workers. Due to the crippling nature of mental illness, efforts need to be taken to improve the conditions of all people who suffer with mental challenges. Staggeringly, "the WHO estimates that 151 million members suffer from depression worldwide"(2010, p. 2). Therefore, knowing these numbers and also recognizing that sufficient resources may not be available in developing communities, policy makers need to step up and do more in insuring that those suffering are not isolated.

The treatment approach in intervening mental illness needs to consider the cultural, societal, economic obligations of communities. Also, any approach needs to consider all the little pieces at work in progressing an individual's mental health, which is why "the human rights-based approach to development recognizes the protection and promotion of human rights as an explicit development objective. It emphasizes among other

things, participation, long-term planning and a multidimensional understanding of poverty" (2010, p.4).

"Addressing Mental Health in Afghanistan" (2002, p.41)

Mental health in Afghanistan is one littered with years of war and economic instability. Historically, Afghanistan as a whole has fallen into a poverty trap ever since the onset of the Cold War in the 70s. Though mental illness is prevalent, there are not enough resources at the ground level to counter the complexities of the mental health epidemic. Willem van de Put's article, *Addressing Mental Health in Afghanistan* (2002), highlights the conditions of Afghanis living with mental illness. A shocking figure outlined by Put is the ratio between mental health medical personnel and Afghani people. It is reported that, "for the 23 million Afghan people in total, [there are] eight psychiatrists and 18 psychiatric nurses (2002, p.41). The lack of sufficient resources and capacity to counter this crisis is reflective in local/ground level approaches towards mental illness. In response to mental illness, community members revert to traditional methods that are spearheaded by mullahs. Traditional healing centres are also stations of mental illness treatment. In Afghanistan, a traditional healing centre called a *Samachel* has historically been known to house and cure individuals distraught with mental illness. Culturally, beliefs

surrounding mental illness are very minimal and dysfunctional behaviour tends to be associated with *Jinns* (possessive alien subjects), *evil eye*, *magic or witchcraft*...etc. Cataloguing his experience, Put describes a *Samachel* by illustrating the rooms as having, "mud floors, no doors, no furniture, and most walls have huge holes, caused by artillery fire. Four male patients are chained to the wall by their ankles, each in a separate room. They look dirty and weak. There are no facilities whatsoever, not even the very basic requirements for defecating. Outside, four more male patients are chained to trees"(2002, p.41). Mentally ill individuals undergo a 40-day treatment where a collaboration of fast, reading of the Quran and herbal techniques are used to cure the individual.

Widespread community behaviours that may be catalyzing mental illnesses include — but are not limited to — domestic violence, forced marriages, and urban migration. A call for tackling these issues are necessary to counter the fragmentation of Afghan communities. Contrary to popular belief, mental health issues are a dire and great concern in order to rebuild this community. Echoed throughout other ethnographies and case studies, it is greatly important that locals are empowered with the resources to handle the mental health crisis in Afghanistan. As eloquently said by Put, "the task of rebuilding Afghanistan has to be taken on by people who may have endured loss and pain,

and most feel weak and ill. In these circumstances, attention to mental-health issues can hardly be called a luxury" (2002, p.41)

Stigma and Depression in Urban Turkey

To showcase a snapshot of stigma surrounding mental illness, I will be shedding light on a thorough study done in Turkey. Societal judgments towards depression is widespread globally, and more so in developing communities. A couple of physicians collectively decided to put together a survey to try and gather qualitative data showcasing people's perceptions of depressed individuals. The study, titled *Public Attitudes to Depression in Urban Turkey* (2004), highlight the negative perceptions associated with mental illness. The researchers cross referenced their findings in Turkey, with research done in other European countries. The results of their research highlight the communal understandings of mental illness. The study looked at perceptions of mental illness specifically in urban settings. A total of 707 subjects were asked to partake in a questionnaire in which a vignette, outlining the everyday experiences of a depressed individual, was used to analyze tolerances towards individuals with mental illness.

Overall, the research identified negative perceptions of mental illness in Turkey. The research highlights that 23% of respondents believe that individuals with depression should not

be "free in the community and 28% stated that they would feel uncomfortable having a neighbour with depression"(2004, p.1012). About 40% were of the opinion that they would not work with depressed individuals, whilst 43% disagreed with the idea of renting to a depressed individual. A total of 65% of individuals surveyed believed that depressed individuals were not marriageable and about 43% of respondents were under the impression that depressed individuals were aggressive. When it came to understandings of what the determinants of mental illness were, 90% saw mental illness as a by-product of societal problems.

Interestingly, the same individuals that were of the belief that depression was a reflection of "social problems" also happened to be the same individuals that wanted to least interact with depressed individuals. This motivated researchers to draw a correlation between people's views towards depressed individuals — having the viewpoint that it was a social problem — and their willingness to accept them into society. When it came to participants' notions on what the causes of depression were, majority were of the opinion that it was due to "psychosocial stress and weakness of personality" (2004, pg.1014).

The overall findings were that depression was heavily stigmatized in Turkey. When compared to other European

countries, the culture in Turkey attributed depression with aggression and fear.

Mental Health in an Insecure Mogadishu

The 1991 civil war that broke out in Somalia left the health care system shattered. Ever since, Somalia has been wrought with instability. Currently, there is no mental health policy in Mogadishu or South-Central Somalia, and very few multilateral organizations that cater to mental health services, are currently based in Somalia. When it comes to mental health in primary health care, South-Central Somalia has a total of 5 trained nurses that are equipped with the capability to identify and treat patients diagnosed with mental illness (WHO, 2009, pg.4). There are no psychiatrists or trained psychologists currently working in the field. Even though there are minimal resources for public healthcare in Somalia, Somalis are more likely to gravitate towards traditional forms of treatment for mental illness. As outlined in the WHO 2009 Report, traditionally Somalis tend to believe that individuals with mental illness are possessed with 'spirits' and therefore Quranic methods are the only viable means of relieving someone of their distress.

Policy wise, there is no legislative appointed body or policy framework that has a mental health component, yet,

"psychotropic medicines are included on the essential medicines list"(WHO, 2009, pg.10). Making medicinal options a standard go-to treatment for mental illness. And as of 2009, there were no budgetary portions allocated towards mental health. That being said, at a communal level there is support for mental health initiatives. Diasporic interventions for mental health emergencies are a commonality. Resource wise, there are 3 mental health hospitals that have a summation of 232 beds. They are: Habeb Public Hospital, which is located in the Waberi District; Habeb Rehabilitation Treatment Centre, which is located in the Madina District; and the Jalalaqsi Mental Hospital, which is located in central Somalia.

Primary healthcare personnel in Somalia have limited available resources to understand how to navigate any mental health facilities. In 2009, when this WHO funded research was conducted, primary care doctors had not even had one interaction with a mental health practitioner. Also, about 2% of, "total hours in undergraduate training for medical doctors [is] devoted to mental health"(WHO, 2009, p.13). About 1-20% of physicians have access to psychotropic medicines to diagnose patients with. Due to the fact that there are no psychiatrists or psychologists practicing in the public sector, mental health personnel are limited to 6 nurses, 70 social workers and 10 health care workers.

Research and data collection on mental health is incredibly
minimal. As outlined in the WHO 2009 report, "there is no mental
health reporting system in the country. The data collection
system is poor and undependable. The country has no data
collection system or epidemiological study on mental health"
(2009, p.15). When it comes to internally displaced persons, there
are no initiatives taken by UN agencies such as UNICEF and WHO
to produce effective programs.

Mental Health in War Torn Iraq:

There is minimal conducted research on mental health issues in
Iraq. Iraq has been unstable with an ineffective medical system
since 2003. The country has yet to implement a mental health
policy. Research conducted by Paul Bolton and others at John
Hopkins, discovered that there have been untreated traumas in
Southern Iraq and Iraqi Kurdistan. The mental health system in
Iraq is underfunded and there are less than 100 psychiatrists in
the entire region. The psychiatrists in the region are also
trained to exclusively treat mentally ill patients with
medications. According to the authors of *Mental Health in Iraq:
Issues and Challenges* (2013), "both community-level mental health
providers and community members describe the equating of mental
health treatment with drugs. Psychotherapies are not widely
known or used" (2013, pg. 880).

One national mental health survey has been conducted so far, with results showcasing that 13.8% of the respondents had an anxiety disorder and 7.2% had a depressive disorder. A 2004 study discovered that 37.4% of Iraqi children had some form of a mental illness (Sadik, 2010, p.2). Currently, mental health care is primarily located at hospitals in which practitioners are not well trained in mental health. According to the researchers, "Other mental health professionals, such as clinical psychologists or social workers, do not exist at levels of any significance in the mental health care system"(2013, p.880). After 2003, the ratio of psychiatrists to the population decreased significantly. About 1 psychiatrist is available per 1 million people (Sadik, 2010, p.1).

There is a lot of stigma associated with mental illness in the Iraqi community and according to researcher, stigma in Iraq, "seems to be greater than in other parts of the world" (Bolton, 2013, p.880). Individuals that have mental illnesses are considered unmarriageable in Iraq, which causes isolation. A study was done in 2010 to identify views people hold towards individuals with mental illness. According to the results, about two thirds of individuals interviewed seemed to associate mental illness with personal weakness. About four fifths of people interviewed also, "thought that people with mental health problems are largely to blame for their condition"(Sadik, 2010,

p.3). Half of those questioned believed that individuals with mental illnesses should not marry. About three quarters of individuals said that they would not disclose to anyone if they had a mental illness.

According to a Medecins Sans Frontieres' report titled, *Healing Iraqis* (2013), "societies which have experienced years of suffering and social upheaval due to long periods of violent conflict not only face high levels of emotional distress, but have a great need of a healthy, productive population to rebuild their country" (MSF, 2013, p.1). This report catalogued various testimonials of individuals currently undergoing counselling. An example of such a testimonial is:

"I came here for the first time, to overcome the situation I'm in. I always have negative thoughts and when anyone starts talking to me I suddenly can't stop crying. I witnessed several explosions go off in front of my house and have had my homes searched by the police several times. These experiences affected my life and my work so much. I tried to talk to my family, but they didn't understand me and didn't listen to me. They say I'm crazy. That's why I came here I want someone to listen to me. I left my work and now I'm a house wife, I don't like socializing with the family at all." (MSF, 2013, p.4)

According to Medecins Sans Frontieres, a national report revealed that 35% of 9,000 Iraqi's suffered from a mental disorder. Another survey in the same year reported that less than 10% of individuals suffering from a mental illness received any medical support (MSF,2013).

Psychosocial Interventions in the Arab World

In the Arab world, the private sector tends to dominate the health domain. For instance, private health services in Sudan make up about 63.4%, 58.7% in Egypt, 58% in Yemen, and 56.1% in Morocco (Gearing et al, 2012, p.52). That being said, out of the entirety of health expenditure by both the private and public, the amount allocated towards mental health does not exceed 2.5% in any middle eastern country. There are about 30 "psychiatric beds per 100,000, while two (Sudan and Somalia) had less than 5 per 100,000"(Gearing et al, 2012, p.52). Psychiatrists in the region are minimal, with 0.5 psychiatrists per 100,000 of the population in 7 countries.

In the study, *Adaptation and Translation of Mental Health Interventions in Middle Eastern Arab Countries* (Gearing et al, 2012), researchers had a look at the effectiveness of mental health interventions in the Arab world. The researchers argued that the majority of global mental health interventions were not adaptable in the Arab world. Evidence-based interventions are

predominately tested out in Western countries and the
implementation of these interventions in the Arab world has in
effect stemmed barriers. A total of 22 interventions were
dissected by the researchers to determine what barriers they
hosted after application in the Arab region.

The very first set of barriers outlined were cultural
clashes that arose such as misunderstandings surrounding mental
illness and gravitation towards informal mental health services,
such as Quranic healers. The root cause of mental illness tends
to be culturally associated with a higher authority, therefore
understandings of cures branch out from that understanding. The
stigma surrounding interventions — that exclude cultural
components — outweigh the urge to seek out resources in the
community. The strong communal component also deters families
from allowing members to speak openly about their mental
illness, out of fear that they may be shamed. Culturally, women
are also less likely to seek out assistance, if the health
practitioners aren't women as well. The last component of
cultural barriers associated with seeking out mental treatment,
is the dissonance in language between said providers and the
locals. Due to the fact that these interventions hail from
Western understandings, the practitioners tend to lack the
necessary communication and cultural skills to treat patients
(Gearing et al, 2012).

The second set of barriers that were looked at by the researchers include access constraints. Out of the 22 interventions researched, 15 particular access barriers were identified. There are two particular forms of access constraints outlined by the researchers: access to services and availability of services. Examples of access to services include, financial inhibition, "gender norms, and insufficient local transportation" (Gearing et al,2012, p.675). Forms of constraints in the availability of services include "lack of professional community-based service providers as well as insufficient resources needed to provide the required services" (Gearing et al, 2012, p.675).

The final barrier that was looked at by researchers is the inefficiencies in "clinical engagement processes" (2012, p.675). This barrier is essentially the misunderstandings patients have towards treatment and the mistrust they may direct towards medical personnel. The researchers outlined that patients were more in tune with approaches that were cognizant of local particularities.

Pills: A Solution for Mental Health in India

The National Mental Health Programme (NMHP) was implemented in India in 1982. This Programme was first undertaken by India after the 1973 inter-regional seminar on the organization of mental health services, that took place in Addis Ababa.

According to the article, *Pills that Swallow Policy: Clinical Ethnography of a Community Mental Health Program in Northern India* (2009), psychotropic medicine has become a headlining solution for mental health issues in India. In 2002, there was a gradual shift away from the original NMHP policy implemented in 1982, and a move towards a policy that was framed around psychotropic medications. Policy makers were keen on revamping the national health system to reflect an approach that "may be scientifically correct" (2009, p.63). The new NMHP policy pulls away from initial calls to integrate mental health policy into community programming and the process of localizing the national framework, and instead "implicitly emphasizes medication" (2009, p.64).

Due to various administrative failures, the 'pill' became a cohesive solution. The NMHP being a central government agenda, conducting solutions at the state level was trickier than originally thought out. States relied on direction from the central government, and the central government expected states to factor in their own solutions. This "led to various problem, which hindered the program's implementation in Kanpur [a particular city], including difficulties in releasing salaries from the state government, intermittent supplies and the poor quality of psychotropic drugs" (2009, p.65). Community health sites are located at the outskirts of rural villages therefore

deeming to be inaccessible. One particular ethnographic account highlights the predominant approach towards patients:

"*A 30-year-old man came to the clinic with a male friend. He reported symptoms of tension and ghabrahat (translated by clinicians as anxiousness or fear). The psychologist asked questions about his symptoms — Did he sleep well? Did he feel anxious? Although he had been ill for a number of years, at no point were the reasons for his ghabrahat explored nor his social circumstances elicited*" (2009, p.68).

Clinicians use forms that are written in the English language to record patients accounts, despite Hindi being the predominant language of the region. Members of the community do not necessary agree with the application of medications as a solution to their mental state, but they aren't given many other options. Once prescribed a 'pill', a patient must decide whether or not it's a necessity for purchase. Even if the patient purchases the medication assigned to them, they are more likely to take the medication incorrectly as a way of rationing.

Rural community understandings of interventions do not align with state objectives. This creates a fission between rural health centres and mental health patients seeking assistance. Majority of practitioners assigned to assist

patients hail from urban centres. As highlighted by the researchers, this creates a dissonance in viewpoints between the urban health staff and the rural patients. The researchers illustrated the community health centre as being "a noisy grocery shop where medications become the most sought-after commodity. Indeed, patient attendance often dropped when free medications were not available" (2009, p.68). Community understandings of the 'pill' have become strictly biomedical, therefore eliminating local language used to describe what patients are experiencing. Their mental suffering is seen as a form of symptoms that need to be dealt with through medicating, yet their external problems are persistent and there has yet to be discussion around how to resolve this concern. The authors fundamentally argue that, "community psychiatry has, in practice, become an administrative psychiatry focused on effective distribution of psychotropic medication" (2009, p.61).

Localizing Health Approaches in '*Bedu*' Jordan

Bedouin tribes in Jordan only make up 3% of the Jordanian population. Their communal way of life calls for a different health method that understands the intricacies of their culture. Application of interventions that have been formulated outside of the region, tend to proliferate greater problems. Traditionally, the Bedouin "society is based on tribal

organization that is characterized by collectivism and fierce loyalty to family, clan and tribe. There is a segmentary patrilineal tribal structure based on tribes(*ashirah*), which is sub-divided into sub-tribes or clans (*hamoulah*), which in turn are divided into families (*fakhdh, ahle*)"(Al-Makhamreh et al, 2012, p.963).

In the study, *Localising Social Work Lessons Learnt from a Community Based Intervention amongst the Bedouin in Jordan* (2012), researchers highlight how practitioners navigate a Bedouin region to digest the specific health needs of the indigenous people in order to curate a health system that addresses local needs. In the study, 5 Jordanian health workers visit remote health clinics to try and understand the immediate needs of the locals in assisting them with the development of an efficient health framework. One component that was addressed was the social construct of *Wasta/Wasitah*. This idea that health workers need to utilize any connections that they may have to better assist locals. For instance, a practitioner recounts her reaction to being told by a patient that she would never go and register her granddaughter's birth at a government office. The practitioner reacted by utilizing her upper-level connections to request assistance for this woman. Spiritual understandings also dictate how Bedouin members filter health problems. For instance, when one of the practitioners met with a woman who was

a *Daya* — which is a "traditional birth assistant" (2012, p.969) — she

had to take into consideration the woman's knowledge and

appreciation for Quran and the use of herbs. This reach for

extended knowledge in a community's idiosyncrasies, should be

vital in developing mental health strategies.

Analysis and Discussion

According to the Substance Abuse and Mental Health Services Administration, in the United States, mental illnesses will be surpassing any physical illnesses by 2020 (Stanciu, 2017, p.2). In comparison to other illnesses and diseases, mental health is incredibly neglected by the global community. According to the article, *No Health Without Mental Health* (2007), "non-communicable diseases [such as mental health] are rapidly becoming the dominant causes of ill health in all developing regions except sub-Saharan Africa" (2007, p.859). Developing countries are less likely to allocate funding towards improving non-communicable diseases, such as mental illness, due to the fact that they are more engrossed in eliminating infectious diseases that have an emergent nature. Not to mention the lack in treatment infrastructure present in low and middle-income countries to support communities.

Any attention being drawn towards mental illness tends to be seen as an inconvenient luxury by many developing communities, causing them to be drawn onto more pressing issues. When it comes to the global community and their understanding surrounding necessities that need to be addressed in low and middle-income countries, there's very little mention of the current mental health crisis. According to the article, *The Unseen: Mental Illness's Global Toll* (2006), "the United Nations

Millennium Development Goals make no mention of mental health,
nor do the Bill and Melinda Gates Foundation's Grand Challenges
in Global Health" (2006, p.458). Even though the article was
published 12 years ago, it still rings true in highlighting the
approaches towards mental health – or lack thereof – taken by
multinational organizations today. That being said, the
Sustainable Development Goals do make mention of mental health
under the 3rd goal, 'Good Health and Wellbeing'. This showcases an
improvement, but does not attempt to go anywhere near the
objective of ensuring mental health be signified as a priority.

As highlighted in the data provided, developing countries
are less likely to incorporate national legislation that
prioritizes mental health. The governance structure in many
developing countries lack any emphasis towards safeguarding
mentally ill individuals, as well as ensuring they receive the
adequate support in treatment. A survey conducted by researchers
outlined in the article, *Scale Up of Services for Mental Health
in Low-income and Middle-income Countries* (2011), showcases that
about 40% of academic/professionals surveyed reported that there
weren't any government policies in place to address mental
health. Even the developing countries that did have a mental
health policy measure in place only had that structure as a
public relations objective with no viable framework in place. As

highlighted by the authors, "an analysis of mental health policies in Ghana, South Africa, Uganda, and Zambia, for example, found them to be weak (in draft form or unpublished) and inadequately implemented. They often lacked feasible plans and adequate resource commitments" (2011, p.1594).

According to the *UN Convention on the Rights of Persons with Disabilities*, "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (2008, p.4). Mental wellness is something that is secured and recognized by the UN. The UN supports upholding the rights of individuals with mental illness, and is affirmed by this convention. That being said, there is no binding measure in place that ensures all signatories stay true to this convention. Therefore, the convention simply becomes words on a document without any real significant impact.

When it comes to actual dollars being delivered to developing nations in the name of mental health/wellness, there isn't much to speak of. In the article, *Donor Financing of Global Mental Health, 1995 – 2015* (2017), researchers interpret estimates of funding towards mental assistance to be less than

1% in every nation. The researchers collected financial records and various budgetary documents from multilateral organization such as the World Health Organization (WHO) and the World Bank — to name a few — and identified the persistent gaps present in funding towards mental health. They found out that NGOs were the largest donors towards mental assistance in developing communities (USD 54 million), followed by the WHO (USD 15 million). Majority of funding towards global mental health hails from NGOs and other private forms of organizations. Due to the fact that government perspectives are not involved in allocation of funding, a lot of the time private donations do not translate into adequate resources for mental health services on the ground. Also, the WHO estimates that for every 1 psychiatrist there are about 200,000 people or more. There is also a minimal amount of mental health practitioners, and minimal mental health training for nurses and other health workers. This indicates that there aren't enough professional resources on the ground to help direct funding in an efficient manner. The *Donor Financing of Global Mental Health* (2017) study touches upon estimates indicating that an investment in depression and anxiety between 2016 — 2030 could potentially result in a USD 310 billion net increase. That staggering figure highlights the need to not only invest in global mental health, due to the economic benefits, but prioritize the need for cost-effective solutions. Without

cost-effective solutions in mind, money allocated to mental health will not translate efficiently.

In line with the idea of cost-effective solutions, there needs to be a redesign of current mental health interventions to allow for a more streamlined approach. Global investments in mental health are minimal because stakeholders do not see the necessity or urgency of funneling money into the sustenance of mental health programs. The view is that an increase in financial assistance does not add up to long-term benefits. According to the article, *Grand Challenges in Global Mental Health: Integration in Research, Policy, and Practice* (2013), researchers identify that countries commit to less than $2 annually, per person, on mental health assistance. In developing communities, funds are normally allocated to the provision of hospital beds in the psychiatric division. This highlights the need for cost-effective mental healthcare in developing communities. Having cost-effective mental health solutions would help offset costs incurred by patients — who do not have adequate financial means to pay a private psychiatrist or pay for travel to access a specialist at a public hospital. Cost-effective solutions would ensure that those who need it the most, get the best alternatives.

Seeing as though there is correlation between mental health

and poverty, it is only natural that sustainable and efficient alternatives are sought out to increase access to services and not cast away individuals that do not have the financial capacity to seek assistance. A great way in implementing a cost-effective approach is to incorporate mental health into primary care. In many developing communities, primary healthcare is publically funded and accessible. As outlined in the data section, in developing communities a lot of mental health resources are only available at the secondary-level. To top that all off, primary/community based healthcare does not have a readily functioning referral process, therefore leaving patients to either look for their own means of support, or to seek out informal health alternatives. In order to utilize primary healthcare in an efficient and smooth manner, mental health needs to be incorporated into the primary health system.

Primary healthcare is a generalized system that promotes practitioners to have a holistic, community based approach. As outlined in the article, *Beyond Symptoms: Defining Primary Care Mental Health Clinical Assessment Priorities, Content and Process* (2012), the idea behind having a tertiary system is to ensure that the healthcare structure works in an organized fashion. When it comes to mental health, a lot of the time the health system believes that a referral process where patients are handed off to a specialist works best. That being said,

primary health workers are presumably the first points of contact that patients have with a practitioner, therefore in attempts of ensuring "access and equity, prevention and early intervention, advocacy, generalism and whole person care within the community" (2012, p.145), mental health needs to be incorporated into primary healthcare. The idea of incorporating mental health into primary care allows for physicians to prioritize the individual as a whole unit and promotes practitioners to develop a solid foundation with their patients, "allowing social, psychological and physical symptoms as well as diagnoses, to be part of primary care professional formulations" (2012, p.145).

One sacred component of incorporating mental health into primary care is utilizing the safety and trust that a community health centre already possesses. The established relationship that has been built between practitioner and patient can be further flourished and adequately made use of. In training practitioners to have an all-inclusive approach, patients are more likely to reach out and not necessarily feel guarded about vocalizing their needs. The establishment of collaboration between the physician and patient, allows for there to be a sense of community due to the responsibility taken on by the practitioner in upholding the rights of the patient. By exploiting the elevated and revered status, granted by the

community onto the physician, the physician can continually
advocate for the prioritization of mental health, and this may
allow for a dwindling of stigma that is normally attached to
mental illness. In valuing the viewpoints of the patient, the
hope is that this validation may work in favour of the community
and improve the psychological distress that a patient may be
experiencing.

The objective to incorporate mental health into primary
care would also potentially help to ease the onset or continual
advancement of physical illness. Due to the fact that physical
illness can impact the mental wellbeing of an individual and
vice versa, treatment should be managed in one communal setting
such as a primary health centre. By mitigating any illness at
the primary level, the hope is that both mental and physical
illness are not proliferated. That being said, the objective
would be that both physical and mental illness be equally
prioritized.

In our understanding of primary healthcare and the
importance of it, we need to also understand the necessity of
justifying informal forms of primary healthcare. In many of the
communities that were outlined in the data section, there was a
tendency for community members to resort to informal/traditional
forms of care as opposed to more western or formal services.

Calls to multinational organizations — such as the WHO — to have evidence-based interventions are great, that being said this approach neglects traditional forms of treatment that may better align with community understandings of mental illness. As outlined by Kirmayer and Pedersen in their article, *Toward a New Architecture for Global Mental Health* (2014), there are two predominate approaches in adapting mental health in community settings. The first is a public health approach which is "grounded mainly in biomedicine and current evidence-based practices (which are still largely produced in high-income countries), and a socially and culturally informed community-based approach that emphasizes the social determinants of mental health and the imperatives of listening to local priorities, strengthening community resources, and developing endogenous solutions" (2014, p.760). Due to a push for more evidence-based approaches implemented in mental healthcare, cultural understandings become eroded causing a dissonance between traditional understandings and western approaches. This neglect to cater to community understandings results in a mistrust between healthcare personnel and community members. By coming up with a one size fits all solution, religious, spiritual, and cultural elements of a community are foregone. In "undermining community autonomy and self-direction" (2014, p.765), this may result in misdiagnosis and poor mental health results which

would discontinue effective solutions. That being said, it is only fair that recognition be given to evidence-based interventions. A sole focus on informal/traditional health treatments may take away from addressing basic mental health needs. Therefore, evidence-based approaches are still necessary, but in harmony with traditional understandings of mental illness treatment.

The social, economic and political environment within a community needs to be considered when trying to implement effective mental health interventions. As outlined in the research, poverty, marginalization, and stress can exacerbate mental illness and therefore these external conditions need to be considered. There is a general assumption that child mortality is linked to the socio-economic conditions of a region and not solely seen as a genetic failure. That same understanding needs to be applied to mental illness as well. Foregoing understandings of mental illness as an embodiment of symptoms, and recognizing that there are many socio-economic explanations behind an individual or community's mental struggles, will help to reshape approaches.

As outlined by Kirmayer (2014), "evidence is not produced on a level-playing field: economic and political forces shape the production, interpretation, and impact of evidence. When the

pharmaceutical industry has set the agenda for research on psychiatric medications it has sought to provide evidence to bolster the marketing and positioning of specific medications" (2014, p.768). This highlights the negativity of basing mental health solutions exclusively on scientific understandings, due to the fact that pharmaceutical companies have a vested interest in making sure that biomedical solutions are maintained and prioritized in interventions. The push for a 'quick fix', can result in a focus on the material and a negligence of any other interpretative explanations. Lexchin, in the article, *Those Who Have the Gold Make the Evidence* (2012), highlights how pharmaceuticals are the main sponsors behind evidence-based approaches and therefore may create a murky bias in the need for psychotropic medications in mental health treatment. There may be pressure by private health centres and the like to report favourably in evidence-based approaches due to "strong financial pressure" (2012, p.248). That being said, there is a general understanding that biomedical approaches are necessary at times, but should not be the exclusive factor in determining a solution for community members.

As outlined in the data section, spirituality — and lack of it — is a major construct in understandings of mental illness, which is why in many communities mental illness is synonymous

with "displeasure of the gods or possession of evil spirits" (Mcilvride, 2017, p.72). This can be an explanation as to why there is stigma associated with mental illness, or perhaps the removal of seeing the human as a complex transcendent soul may explain why we hold such judgements against those who seem 'abnormal'. The evolution of the scientific domain has created trust and reliance in medicine throughout the Western hemisphere. Approaches towards psychiatry have become dominated by this black and white method of creating a tablet cure that'll solve the issue. There is an understanding that technological and scientific methods are of great use, but when approaching mental health in developing communities, the emotional, spiritual, transcendent and relative understanding needs to be digested. These two competing views — tablet versus spiritual, talking cure — need to be formulated in a harmonious, holistic way. By viewing the human as a mechanism that needs to be 'fixed', the role of spirituality becomes unnecessary. This materialistic approach goes against many understandings of communities in the developing world. Therefore, in indigenizing primary care interventions, there also needs to be a foundational understanding of the soul and how communities may value spirituality. Without incorporating that into primary mental health care, there may be a disconnect between health-workers and patients.

Ultimately, there is a necessary call for psychologists and other healthcare practitioners to establish a caring and understanding relationship with the communities they serve. As counterintuitive as it sounds, removing the institutional frameworks from the healthcare establishment, to try to understand the individual needs of every patient, is the top-dollar approach. Therefore, a strip away from this stringent medical focus, would be ideal in mental health practice.

Cataloguing appropriate interventions outline the necessary steps needed to be taken in order to counter mental illness in developing communities. That being said, it is also pertinent that there is a focus on preventative measures. As outlined, mental health and socio-economic conditions are correlated, therefore, countries and multinational organizations need to understand that, and apply policies with that in consideration. Preventative approaches are necessary in a community because epidemics are a public health concern, and communities need to be readily aware of that. Having measures in place to counter health concerns in the future, is something that is of great importance. Due the fact that many low and middle-income countries are not fully equipped with an advanced public health system, preventative methods to counter mental illness might not be structurally in place. Preventative methods may be costly initially as a start-up, but the idea is that investment in a

healthy and viable society would translate into many benefits, which would be favourable economically as well.

When it comes to implementing preventative measures in a community, there must be an understanding of the epidemiology – i.e. the underlying cause of illness in any given region. In order to understand that when looking at mental illness, one has to shift through and figure out the core determinants. As showcased earlier in this thesis, socio-economic determinants seem to be the most convincing originators of mental illness. A downturn in socio-economic status has proven to be correlated with adversity. Understanding that socio-economic determinants are a core component of mental illness, would also allow global health workers to realize that approaching mental illness is greater than just alleviating the symptoms – i.e. stress, depression, feeling suicidal. Recognizing that mental illness will be recurrent if socio-economic situations are not handled, is the approach that stakeholders should be considering. As outlined by the article, *Interventions to Mitigate the Effects of Poverty and Inequality on Mental Health* (2017), there are many recorded poverty focused interventions that have been introduced as a counter to mental illness. They include: a microenterprise program in Uganda, an improvement in accessibility of loans in South Africa, and a cash transfer initiative in Mexico (2017). To no-one's surprise, there was an

overall positive response to these interventions, which highlights that poverty focused methods should be used as preventative options in approaching mental illness.

When it comes to untreated mental illness, there are long-term economic implications for a society; such as a chronic disability, individual's that are disabled may have a more challenging time in contributing as effectively to a community, and suicide, which sadly revokes any community of a contributing member. These implications are problematic for a society and more-so in low and middle-income communities where there isn't as much support in the mental health infrastructure — which is understandably so because of a lack of viable resources such as research, expertise…etc. In forming preventative measures, there needs to be a heavy focus on the socio-economic situation in low and middle-income countries. That is the most effective way to approach this concern. Now, when it comes to medical treatment, health workers need to understand the benefits in integrating historical, economic, political and social understandings of a community into their framework. This is important because in understanding the various components and circumstances within a community, the health practitioner can cater to their patient in a more effective manner. That being said, there needs to be a two-headed approach in tackling this mental health epidemic. Firstly, a team of experts from various fields such as economic,

political, social…etc, need to sit at the decided table and collectively incorporate mental illness legislatively and in doing so the hope is that mental health is prioritized in all sectors of society and that it is prevented before its onset. And secondly, a treatment team needs to devise an integrated and sustainable approach that focuses on holistic primary mental health care. By approaching this calamity in such a manner, mental illness in developing communities can be mitigated competently.

<u>Conclusions and Recommendations</u>

This paper looks at the global community's lack of prioritization on mental health and the social implications that result from that divergence. International community recognition that mental health is a cause for concern, is the first outlined step in this long process of implementing measures to help offset this global issue. As evidently outlined, global neglect towards mental illness has direct implications on the economic success within a community. Morally, there is a fundamental need to look after marginalized members that experience the negative repercussions of living with mental illness. With regards to holding an entity accountable, in this research it was touched upon that multinational organizations, such as the World Health Organization have to bear the responsibility in producing effective, holistic and ethical intervention and prevention options. There is definitely going to be a set of disagreements about certain viable methods that are brought to the table, and that is an appropriate reaction. That being said, practitioners should make it habit to broach mental illness at the primary level and not leave it to be a secondary or tertiary healthcare problem.

As highlighted in the data section, many regions have vulnerable community members that are not receiving adequate

support from the national or international community. A couple of commonalities between all regions is the concentrated medicated approach in treatment. There should be a degree of medicinal options for countering mental illness, that being said there needs to be an understanding that mental illness can be a psychological representation of socio-economic conditions within these regions. Evading that core issue, will only result in a community becoming even more dependent on medicinal options. Therefore, there needs to be a pull away from a strict treatment approach and the development of preventative methods needs to be a priority.

When it comes to recommendations, the very first proposal that I would like to bring forth is a focus on increasing financial resources for a more research centered focus on tackling mental illness in developing communities. The inadequate amount of funding allocated to mental health research is of great hindrance. When it comes to available research surrounding mental healthcare in developing communities, there is hardly any. Unfortunately, it's the reality and mainly why there isn't much attention being shed on mental illness in developing communities. What is available is quite limited, hence why there was not a concentration on one particular region in this research.

To understand the global analyses and current research being undertaken on mental health, I had a look at the latest *Mental Health Atlas* (2011), published by the WHO. The Mental Health Atlas (MHA) is an aggregate collection of surveys "obtained from 184 of 193 Member States, covering 95% of WHO Members States and 98% of the World's Population" (2011, p.11). The MHA categorizes findings under these overarching points: governance, financing, mental health services, human resources, medicines for mental and behavioural disorders, information systems. Surprisingly, a lot of the material provided seemed to be very positive and contrary to my own discoveries. That being said the data provided was self-reported, therefore perhaps that may explain the contrast in results. This brings me to my other point that any research conducted should be free of any inflation or misleading data. The main way to address that is to have an international body of appointed individuals conduct the research to ensure that there is no tendency for partiality.

My final recommendation is a call to push for legislative action. Bilateral agencies, private foundations and multilateral organizations all have to burden the responsibility in ensuring that there are legal measures in place to not only safeguard mentally ill individuals, but to guarantee that there are binding agreements to allocate a certain percentage — upwards of the current standing 1-2% — in incorporating mental health

preventative and treatment methods. These methods should be strategically organized, so that funding does not fall through the cracks. Therefore, cost-effective solutions are first and foremost the main objective in any implementation of successful interventions.

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