SPECIAL ARTICLE

MENTAL HEALTH IN THE EASTERN MEDITERRANEAN REGION: *FOCUS ON WOMEN, CHILDREN, THE ELDERLY AND REFUGEES*

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ABSTRACT

The Eastern Mediterranean Region (EMR) has some of the world's poorest health metrics among the WHO regions. It has the highest prevalence of mental disorders worldwide. This is largely attributable to the region's ongoing persistent humanitarian crises, which from one perspective, increase the need and demand for mental health services, while on the contrary eroding the capacity of health and social care systems to provide the basic care. With insufficient human, structural, institutional, data and financial resources, these mental health care systems continue to suffer from neglect and apathy. The situation is exacerbated further by the stigma, discrimination, and human rights' violations that people with mental illnesses face, where women, children, the elderly, and immigrants are the highly susceptible population groups. This paper aims to outline the issues and risks linked with mental health in the Eastern Mediterranean Region, and also to provide practical and equitable recommendations that seek to address the past indifference and neglect in order to advocate the importance of mental health in public health.

KEYWORDS

Global Burden of Disease, Health Priorities, Non-communicable Diseases, Sustainable Development, Mental Health Services

INTRODUCTION

The Eastern Mediterranean Region (EMR)–comprises 22 countries and territories in the Middle East, North Africa, the Horn of Africa and Central Asia and it faces emergencies, perhaps unprecedented in its history. Armed conflicts exist in 12 of the 22 countries in the region. The region's 680 million people represent 9% of the world's population, but the EMR hosts 43% of people in need of humanitarian assistance and is the source of humanitarian help to 64% of the world's refugees. Pakistan has hosted over four and a half million Afghan refugees for over two decades. Still, it endures terrorist attacks along its Western borders.[1]

These events have a significant influence on the health of refugees and the local population. Direct health effects include gender-based violence, traumatic death and disability, disruption of the health system, and a rise in infectious disease, malnutrition, obstetric problems, and non-communicable diseases (NCDs). The EMR has some of the lowest health metrics in the entire globe. Most governments struggle to implement the SDGs (Sustainable Development Goals). Conflict threatens global health security because affected nations are less equipped to prevent, investigate, and manage disease outbreaks. Worldwide, approximately 70% of disease outbreaks take place in volatile and conflict-affected areas. The greatest cholera outbreak in recorded history occurred in Yemen. Sudan saw six concurrent disease outbreaks in the second half of 2019. Conflict caused the wild poliovirus to resurface in Syria, one of the three nations where it is still endemic. Afghanistan and Pakistan are the other two.

The average core capacity value for the 12 conflict-affected countries in the International Health Regulations (IHR) is much lower than for other countries in the region, putting them at greater risk of the spread and public health consequences of the outbreak of coronavirus disease 2019 (COVID-19) and other epidemic-prone diseases. As a result, the WHO Global Strategic Plan for COVID-19 Preparedness and Response prioritises technical and operational support from international partners for countries with deficient health systems. As of February 28, 2020, COVID-19 had already impacted ten countries in the region, including Iraq, Afghanistan and Pakistan.[2]

The prevalence of mental illness is rising, which has a significant negative influence on health, along with substantial global social, human, and economic repercussions. The greatest incidence of mental illnesses is found worldwide in the Eastern Mediterranean Region. Although those with mental illnesses are most susceptible to discrimination, among them, women, children, the elderly, and immigrants are most at risk.[1]

Depression and anxiety, the two most prevalent mental illnesses, are more common in women who experience them earlier in life. The Institute for Health Metrics and Evaluation (IHME) demonstrated how women experience greater psychological distress throughout the region in a preliminary study examining the prevalence of dementia in EMR (1990-2013), the Global Burden of Diseases, Injuries, and Factors Study (GBD 2013). In 2013, women lost 3.3 million disability-adjusted life-years (DALYs) due to depression, while males lost approximately 2 million DALYs. Anxiety caused over 1.9 million DALYs for women in the region, but only about 1.3 million DALYs for men.[3]

For children and youth, specialised services in EMR are slowly expanding, but not quickly enough to fulfil the demand in a region with a large proportion of young people. Most of the mental health services provided in the EMR are geared toward mentally healthy people. Only six of the region's 22 countries offer child and adolescent psychiatric beds, and only 12 have

minimal outpatient services. The workforce in these institutions is substantially less than the global average. Few attempts are made to educate and prevent mental illness in the youth, particularly children and adolescents. In addition to a dearth of mental health specialists, specialised mental health education for children, women, and adults is also poor.[1]

Mental illness is also known to begin at a younger age. Adults are also affected, albeit their symptoms vary. The most frequent mental disease in this age range is depression.[4] Chronic mental illness impairs understanding, functioning, and physical health in the suffers. Loneliness, perceived loss of function, and frailty are all contributors to this population's poor health. Elderly persons have a high status in the region and are typically cared for by family members. However, in rare cases, elderly persons may be admitted to psychiatric hospitals for extended periods of time as a culturally acceptable alternative to a nursing home.

Conflicts, in addition to age and gender, are key causative factors in mental health disparities. Civil unrest or rioting, political turmoil, and natural or disasters of human-origin have overrun several EMR countries. At least one in every five people living in conflict zones suffers from a mental health disorder. As a result, the prevalence of mental diseases is expected to climb even more. According to the United Nations High Commissioner for Refugees (UNHCR), women and girls account for over half of all refugees — homeless or stateless — putting homeless individuals, pregnant women, family heads, the disabled, and the elderly at risk.[5] "Those who are forced to return to their homelands, so-called 'returnees,' are among the most vulnerable."

Internal, regional, and worldwide migration of the region's population has altered the social profile of EMR countries. It is critical to record the payment made by participating countries. The consequence has been processed on various levels. The long-term mental health repercussions of refugee status must be considered for current and future generations. Trauma, such as shell explosions, fear of persecution, and the loss of loved ones, can have a tremendous impact on the lives of refugee children. This is worsened by the obstacles that children experience once they arrive in the host nations, such as a lack of education, language barriers, and discrimination. Among the determinants of mental health disorders in this population, post-migration factors are powerful predictors. The need for psychological and social support between refugees varies significantly.

World leaders through Sustainable Development Goal 3.4 (WHO, 2019) recognized the promotion of mental health and well-being as a health priority for the first time. Specifically, sections four and 23 provide a solid basis for inclusion by asking nations not to leave anyone behind, including refugees, internally displaced persons and immigrants.6The 2016 New York Declaration for Refugees and Migrants commits particularly to refugee children and provides measures for implementing those commitments. Points 26, 29, and 32 emphasise the necessity of addressing the needs of refugee children who have been subjected to physical or psychological abuse and focusing on their psychosocial development. To this day, mental health professionals in refugee countries grapple with the plight of refugees and refugee-seeking children.[1]

In the modern digital age[7], where access to information and communication is more efficient, it is unacceptable to continue in a state of insufficient knowledge, inadequate staff, and poor services. Since data are important, they will not be useful without understanding the context of the information. The COVID-19 epidemic, with all its negative effects on health, health services and human health, has enormously affected the elderly. Considering the extended family networks within EMR, it is difficult for older adults to adapt to the social distancing, lockdown, and other safety practices necessary to control the spread of COVID-19. Many of the older adults in the region may not be familiar with technology and thus have difficulty communicating on-line with their families. The effect of such isolation on their mental health has not been studied in the region. In the other extremes of age, children in many countries lost almost two years of education in a normal classroom setting, along with all the behavioural and social benefits associated with such experience. It is not yet known how this will reflect on future generations and society.

Discrepancies in Mental Health Issues in EMR Countries

The areas in the Eastern Mediterranean region, despite their many similarities, have significant differences: while some countries have experienced growth and development, others have witnessed extreme adversity with subsequent deterioration in health parameters. Although there is evidence of the rising prevalence of mental disorders, mental health remains the most neglected field in public health with very little investment, even in the more affluent countries among EMR.[1] The last decade has witnessed an improved investment in mental health and expansion of services, with a focus on community outreach programs, mostly in the six Gulf Cooperation Council countries. Such expansions are a major step towards service improvements, though they remain insufficient to meet the actual demands.

The extent of demand for mental health care is difficult to determine accurately because of the shortage of relevant data. Data from the region are variable in availability, accuracy, and reliability. In countries that do collect regular data on mental health indices, the published data do not target areas of inequality in healthcare. Among the most striking inequalities: the physical/mental health divide stands out. This is not unique to the EMR, as in many countries budget cuts are often blamed for redirecting resources to physical health as opposed to mental health. In saying that, in the affluent countries in the EMR, such a divide is still too obvious. Very few mental health hospitals ensure the right of patient's privacy. For instance, 'the right to be involved in their own management decisions' is not as strictly practised by patients with mental illness. Healthcare providers may themselves contribute to the stigma suffered by these patients.

Stigmata associated with mental illness, though an international phenomenon, is prominent in the EMR. People with symptoms of mental illness would often seek several traditional and religious healers before eventually seeking specialised mental health care. They do this often late in their illness, with subsequent negative effects on their prognosis and function. Healers cannot all be categorised as similar. While many are fraudulent in their practices and abuse people, others implement religious principles in healing. Few countries in the region have attempted to work collaboratively with established religious healers. Any efforts made have been sporadic. The divide between spiritual approaches and medical practice needs to be narrowed for effective mental health delivery in this part of the world to be made more acceptable and less stigmatised in the eyes of the public.

The COVID-19 pandemic caused well-known disruptions to health services internationally. The existing resources allocated for mental health were further reduced, despite evidence of increasing mental distress during the pandemic, and the recognised need to build Mental Health Psycho-Social Services (MHPSS), most countries in the EMR either received little or no government funding to cater to this need. Within EMR, women and older adults are expected to benefit the most from outreach mental health care. Such disruption in health delivery is likely to have had its toll on their mental health and function in society.

The situation in relation to mental health legislation and national policies has improved with more EMR countries having a policy or law guiding mental health practice. These laws, though in existence officially, are not yet implemented in some places. Embedded in these laws, the rights of patients with mental illness are clearly defined. While laws and policies may exist towards the protection of children, women and older adults, these laws are not enacted in many countries, and deeply rooted cultural practices take precedence. Such practices are often detrimental to these vulnerable populations, especially women. For instance, although the law protects women's autonomy in making decisions for admission to mental health facilities and discharge, such autonomy is jeopardised by undue influence from family members, especially husbands and/or fathers. Laws are enacted to protect women, older adults, and children subject to abuse. The consequences of reporting and the outcome for the abused remain doubtful and at times counter-productive. Safe and protected placements are not always available.

Culture, Family Traditions & Stress in Women

Arranged marriages remain the most common form of marriages in the EMR. Some of the challenges in a mental health context include:

- Concerns over confidentiality of medical records are a major barrier to help-seeking behaviour, especially noted among women and adolescents. Families worry that having a record in mental health may bar the chances of their daughters getting married. Sadly, these worries are valid. Although men share similar worries, the consequences are more severe for women.
- Women are reluctant to report intimate partner violence (IPV) as the husband is often a close family member. Reporting is seen as damaging to the extended family's relationships and reputation. Women may fear retaliation by their own immediate family members.
- In such close-knit family settings, childhood sexual molestation, incest or abuse may be concealed, again to protect the reputation of the larger family, especially when the abuser is a family member.
- Mental health education and prevention are not included in the school curricula. Some independent or private schools may provide talks addressing mental health aspects of childhood, e.g. bullying, the importance of sports and sleep. However, this is neither consistent nor mandatory. Policies for addressing the needs of children with mental health difficulties within the education system are not always in place. Many schools do not have a school counsellor who can support children with difficulties.

Proposed Region Specific Actions

- Strategies for the growth and delivery of mental health services need to involve relevant stakeholders, in particular Non-Governmental Organisations (NGOs) and people with relevant experience. Collaborative efforts between government agencies and the community are fundamental for mental health services to be person-centred and provide the right care to the right person at the right time.
- To facilitate improvements, monitoring progress and comparisons across the region to be made more accurately, a few steps are vital. For instance, improved data collection, establishing key performance indicators (KPIs) for different aspects of mental health service delivery, with an emphasis on monitoring vulnerable groups.
- Promote research in mental health of vulnerable populations.
- As a consequence of frequent political turmoil & wars in this region, millions of civilians have sought refugee status elsewhere, for their family's safety. There is a dire need to explore the mental health effects of such displacement on refugees within the region and internationally. The politicians and the world owe it for immediate relief, reduction and prevention of the suffering of civilian populations in the future.
- Dearth of experts in psychiatry and psychotherapy: It is recommended for the region to explore teamwork/collaboration with paramedical and social services, which is vital to utilising available resources in their countries. The introduction of tele-mental health can facilitate such cross-country service use.
- Awareness of mental disorders: Psycho-education for community medical officers, nurses and social services, besides the creation of the understanding of common Psychiatric disorders and Psychological First Aid should be fundamental in all community health courses.
- Maternal care centres and associations of Obstetrics/Gynaecology, primary health care clinics, in identifying mental health issues in women. Particularly in the childbearing and Menopausal stages. Antenatal classes, must be mandatory for young couples and those going through difficult pregnancies.
- Adequate secure facilities for women, children and older adults subject to abuse, that ensure they can continue to live their lives in a safe and dignified environment and children may continue their education uninterrupted. Shelter Homes in every large city for Distressed Women (for refuge, legal support, skills training and rehabilitation in society)

- Residential facilities that provide a home-from-home environment are needed for the minority of cases of older adults who are left by their families in acute psychiatry hospitals long term.
- Must build on the societies' strengths in the EMR countries, shifting the focus of mental health support provision from hospitals to support groups within the community, trained in mental health first aid. Groups can include facilities within neighbourhoods for women and older adults as well as refugees, and in schools for children and adolescents.
- Provide Lists of websites and centres that can offer assistance to those seeking help in the region. Regional collaboration to establish a valid mental health promotion and prevention curriculum for the education system, to be provided in schools and centres of higher education.

Individuals in EMR Countries

Participate in community health promotion, personal and social development through providing information and education for health and enhancing life skills

CONCLUSION

Stigma related to mental disorders, though an international phenomenon, is often reported (anecdotally) as being much higher in the EMR countries. Although tele-mental health has been practised in many countries for a few decades, investment in tele-mental health in this region has not kept pace or been utilised to the extent possible. In Pakistan, Zoom Consultations have been a valuable tool to help families and patients during the COVID lockdown. On-line consultations were made available in most of the large cities of Pakistan. And outreach support has become common with the use of cell-phones. Media, radio and TV, besides the medical aspects of COVID, have highlighted anxiety and depression to be a common finding in patients and been a valuable public education tool, though not utilised to its full potential.

With the requirements for lockdown and social distancing during the COVID-19 pandemic, introduction of tele-mental health was an obligatory consequence and several countries in the region provided prompt funding to establish the service. Data from a few countries in EMR show the number of no-shows in mental health clinics declining with the introduction of tele-mental health. It is a more acceptable option in societies with such a highly-stigmatised attitude towards mental illness. This service is expected to continue post-pandemic; and it is recommended to expand tele-mental health, reaching out to a wider population, especially those most vulnerable with difficulty in accessing services in person.

- Another positive outcome of the pandemic was the need to rapidly establish helplines. Although initially created to support the public with COVID-related enquiries, this has expanded to address the rising mental health consequences of the pandemic. Gradually, helplines have become widely used to address all mental health enquiries. This is another service that is recommended to be continued post-pandemic and to further evolve as an instrument to facilitate communities to seek help regarding mental health issues.
- Some countries within EMR have initiated medication delivery service for people with mental illness during the pandemic. This was highly favoured by patients as it addressed their concerns with stigma as well as any practical challenges in securing medication. Building up and expanding on medication delivery or other similar innovative approaches to care provision will encourage help-seeking behaviour among those who need it.
- Establish clear referral pathways and integrated care between mental health services and other organisations addressing the needs of women, children, older adults and refugees with mental health needs.
- It is vital to explore financial support for refugees with mental health needs whose legal status in the host country may not be established.

Implementing change

Strategic interventions, like strengthening mental health literacy programmes, are essential to empower persons with mental health problems and those battling stigma and discrimination. Public education programmes with a special focus on parenting skills, maternal mental health, school and workplace mental health are important instruments of change in communities. Life skills education with active involvement of the persons and families with mental health problems that have been rehabilitated would have a tremendous and important impact in communities, particularly in suicide prevention and diminishing the impact of stigma associated with mental health and promotion of emotional and mental well-being.

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