

GLOBAL MENTAL HEALTH:

Some Perspectives
on Challenges and
Options for Scaling
Up Response

World Bank Group
Global Mental Health Initiative

"It was as if God had decided to put to the test every capacity for surprise and was keeping the inhabitants of Macondo in a permanent alteration between excitement and disappointment, doubt and revelation, to such an extreme that no one knew for certain where the limits of reality lay."

-Gabriel García Márquez

"One Hundred Years of Solitude"

1982 Nobel Prize in Literature-winning Colombian author

"Almost no one in society is left untouched by mental illness. Directly or indirectly, sometimes without even knowing it, mental illness affects nearly everyone at some point in their lives."

-The Honourable Ginette Petitpas Taylor, Minister of Health, Canada

Addressing the "Moving the Needle" Symposium, World Bank Group

International Monetary Fund Spring Meetings, April 19, 2018

And I've always been strong
But I've never felt so weak
And all my prayers have gone for nothing
I've been without love
But never forsaken
Now the morning sun
The morning sun is breaking

-Bruce Springsteen

"The Depression"

"Every day, millions of men, women and children around the world are burdened by mental illness. Yet mental health too often remains in the shadows, as a result of stigma and a lack of understanding, resources, and services. Two decades ago, we faced a similar situation with HIV and AIDS. People affected by AIDS faced severe stigma, and there was a widespread failure of policymakers to acknowledge or address the growing number of people dying in the world – especially in Africa – from the lack of access to affordable treatment. It was unjust, it was wrong, and it was unleashing a health and development catastrophe. So a group of us decided to raise our voices and bring HIV and AIDS out of the shadows, and we demanded action. Today, we are here to bring mental health into the spotlight and squarely on the global development agenda where it belongs."

Jim Yong Kim, President, World Bank Group

High-Level Opening Panel "Out of the Shadows: Making Mental Health a Global Development Priority"

Flagship Event at 2016 IMF/WBG Spring Meetings

Washington D.C., April 13-14, 2016

"I decline to accept the end of man. It is easy enough to say that man is immortal simply because he will endure: that when the last dingdong of doom has clanged and faded from the last worthless rock hanging tideless in the last red and dying evening, that even then there will still be one more sound: that of his puny inexhaustible voice, still talking. I refuse to accept this. I believe that man will not merely endure: he will prevail. He is immortal, not because he alone among creatures has an inexhaustible voice, but because he has a soul, a spirit capable of compassion and sacrifice and endurance."

William Faulkner

"Speech at the Nobel Banquet at the City Hall in Stockholm, December 10, 1950"

1949 Nobel Prize in Literature-winning United States author

"The global fight to transform mental health care will be won in ordinary communities, by ordinary people. Won in homes, schools, workplaces, local clinics, and small residential care facilities. Won by families, lay caregivers, nurses, psychologists, and patients providing peer support, as well as by psychiatrists. What will this great victory look like? It will look like normal life. Like individuals and families living happily, building strong relationships, working productively, where before they could not."

- Healing Minds, Changing Lives: A Movement for Community-Based Mental Health Care in Peru. A Report by the World Bank Group and Cayetano Heredia Peruvian University, 2018

ACKNOWLEDGMENTS

This compilation includes blogs and an article that appeared over the 2011-2018 period. It was put together by Patricio V. Marquez, Lead Public Health Specialist, HNP GP, and Coordinator of the World Bank Group Global Mental Health Initiative. The blogs were posted at World Bank Group sites, and the article from *The Lancet* is a summary of the main messages from the WBG/WHO global mental health event “Out of the Shadows” that was held during the 2016 WBG-IMF Spring Meetings in Washington, D.C.

Washington, D.C. November 2018

For additional materials, visit: World Bank Group Mental Health site:
<http://www.worldbank.org/en/topic/mental-health>

PREFACE

Why Invest in mental health?

- The 2030 Agenda and the Sustainable Development Goals integrated promoting mental health and well-being, strengthening the prevention and treatment of substance abuse (Goal 3), and protection and promotion of rights of persons with mental health conditions and psychosocial disabilities (Goal 4, 8, 10, 11 and 17) as global priority areas until 2030.
- Mental illness and substance use disorders impose an enormous global disease burden. There is a frequent comorbidity and a notable link between mental disorders and other costly, chronic medical conditions, such as cancer, cardiovascular disease, diabetes, HIV, and obesity, as well as a host of risky behaviors, which lead to premature mortality and effects functioning and quality of life. Mental and substance use disorders also cause a significant social and economic burden, which is worsened by low levels of investment and service availability, as well as widespread stigma and discrimination.
- Poor mental health can undermine human capital development, and impacts on economic growth and prosperity of countries, especially through productivity losses at both individual and societal levels. People with mental health conditions are more likely to discontinue full-time education early, and at work, mental ill-health contributes to lower productivity and greater sickness-related absenteeism (with respect to both patients and their caregivers); the risk of unemployment is also much higher. The education of children raised by parents who have untreated mental illness is also undermined when young children are unprepared to learn because their caregivers were not able to provide the nurturing care they require because the society fails to support them properly. Mental health conditions are the most common cause of marginalization, exclusion and deprivation, which contribute to violence, social isolation, and suicide.

What Is Needed?

- Confronting the public health and development challenge of mental disorders will require additional funding to bridge current resource gaps.
- Multisectoral funding must be leveraged to scale-up mental health interventions, while promoting synergies with other health and development programs to reduce duplication and inefficiencies.
- An integrated multi-pronged approach to scaling-up mental health service delivery also would enhance access to and awareness of mental health within a community, thereby improving treatment options and reducing stigma, as well as protecting and promoting human rights of persons with mental health conditions and psychosocial disabilities through ensuring inclusion, accessibility and reasonable accommodations in family, community, education, employment, disaster risk reduction and humanitarian action, and all other sectors.

What Does This Compilation Offer?

- The compilation offers some perspectives on the challenges and options for scaling up a sustained global response to the prevailing mental health inaction.

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GLOBAL MINISTERIAL MENTAL HEALTH SUMMIT, Tuesday 9 and Wednesday 10 October 2018, County Hall, London, UK: RECOMMENDATIONS: “The economics of, and investment in, mental health workstream session”

1.

The Rising Importance on Non-communicable Diseases in the World

The cat is out of the bag: UN summit on NCDs



Submitted by Patricio V. Marquez On Wed, 09/21/2011

As a World Bank staff member, I feel privileged to have participated in two landmark global public health events.

In June 2001 at a UN General Assembly Special Session, world leaders collectively acknowledged—for the first time—that a concerted global response was needed to arrest the HIV/AIDS pandemic. This led to the establishment of the Global Fund [1] and bilateral initiatives such as PEPFAR [2], which helped fund a scaled-up response to HIV/AIDS [3], as well as to malaria and tuberculosis. The net result for the most part has been impressive: a dramatic expansion in access to treatment that has saved millions of lives, a significant reduction in the vertical transmission of HIV (mother to child), technological progress resulting in cheaper, more effective treatments, and better knowledge about HIV transmission to guide prevention efforts—while highlighting the need to revamp health systems [4] to make the effort sustainable.

I'm in New York this week at the UN Summit on Non Communicable Diseases (NCDs), where more than 30 heads of state, 100 ministers, international agencies, and civil society organizations are discussing a pressing global health issue: NCDs [5]. This is a policy nod in the right direction, as NCDs have been largely ignored in development circles even though they cause two-thirds of all deaths in the world (most of them prematurely) and long-lasting ill health and disability, and due to NCDs' chronic nature, increase the risk of impoverishing millions of people who lack or have limited access to health systems.

In spite of the high expectations for the Summit, there is a sober realization that we are living in a different world than in 2001. Because the severity of the economic slowdown and fiscal deficits—particularly in the developed world—may constrain international assistance in the upcoming years, there is a growing understanding that countries will need “to do more with less” and that they “cannot treat their way out of the NCD challenge” as stressed in a World Bank report [6] launched prior to the Summit.

So, I am optimistic that the post-Summit will bring forward some sound and effective approaches to deal with NCDs. The last ten years of global public health history offer multiple lessons to guide the response, particularly to avoid the false dichotomies of communicable versus non-communicable diseases, prevention versus treatment, and vertical programs versus health systems—they are mutually reinforcing. And, the World Bank, as a multisectoral institution, is well-positioned to assist countries in adapting (I would like to stress adapting and not adopting.) those lessons to their respective institutional and cultural realities—particularly in dealing with some of the social determinants of behaviors (e.g., smoking) and biological risks (e.g., obesity, hypertension due to poor diets high in trans fats, saturated fats, salt, and sugary drinks) that are associated with the onset of NCDs, as well as to strengthen the health services centered around a strong primary care system and universal health financing arrangements.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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U.N. Declaration on Non-Communicable Diseases: How Can We Move Faster?



Submitted by Patricio V. Marquez On Mon, 07/14/2014



Three years have elapsed since world leaders adopted the Political Declaration on Non-Communicable Diseases (NCDs) at the United Nations General Assembly (UNGA) in New York. In doing so, they committed to develop national plans to prevent and control NCDs, along with targets to monitor the progress achieved.

Last week, a similar high-level meeting took place at the UNGA to assess efforts made since 2011 to implement those commitments. So what is the score card?

The progress achieved thus far appears to be mixed. Indeed, as the World Health Organization (WHO) Director General, Dr. Margaret Chan, stressed in her opening remarks at the meeting, *“I see no lack of commitment. I see a lack of capacity to act, especially in the developing world”*.

She backed up this observation with both information about efforts made by governments to move this agenda forward and recent data from a 2014 country profiles report prepared by WHO that shows the current high and increasing global mortality from NCDs. It is estimated that 38 million people die each year from NCDs, mainly from cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, and that over 14 million deaths from NCDs occur between the ages of 30 and 70, of which 85% are in developing countries.

The unfortunate fact behind this situation is that these premature deaths are largely preventable if simple, cost-effective and affordable interventions to reduce biological and behavioral risk factors for NCDs are implemented. Health systems should be retooled and strengthened to respond effectively to this challenge, taking into account evidence from accumulated knowledge and experience across the world, and recent scientific and technological developments.

Given the many political declarations and government commitments, what is hindering a scaled up and sustainable response to the NCDs (and I would add road traffic injuries) challenge?

As NCDs and road traffic injuries overtake communicable diseases as the leading causes of mortality and morbidity in most of the world, Dr. Chan advocates for a major shift from the prevailing biological, clinical and curative-oriented paradigms that have governed the way societies organize and fund health systems, to one that stresses health promotion and disease prevention. This new model would focus on social determinants of health and changing behaviors; move from short-term management of acute episodes of ill health to long-term management of chronic health conditions, with their complications and comorbidities; and be driven by concerted action involving multiple sectors, business partners, and community actors.

The above shift is inescapable. As Dr. Chan noted, while health systems bear the brunt of NCDs (and road traffic injuries), they have little control over their causes. Indeed, as she said, *“The health and medical professions can plead for strong tobacco and alcohol legislation, more exercise, and healthier diets. We can treat the diseases and issue the bills, but we cannot re-engineer social environments to promote healthy lifestyles.”*

Therefore, it should be clear to all of us working in the health sector that an effective, government-led, multisectoral effort needs to be advocated, launched, supported, strengthened and operationalized to deal with NCDs (and road traffic injuries) as we move through the second decade of the 21st century.

When reading Dr. Chan’s remarks, I was struck by the revolutionary tone and wisdom in her words. They vividly brought back to me lessons and inspiration from my student days, when I read the work of 19th century public health pioneers such as Rudolph Virchow, one of the founders of social medicine [1] movement, and John Snow, one of the fathers of modern epidemiology [2]. The more recent writings of a generation of social medicine practitioners in Latin America and the Caribbean further stress that successful health promotion and disease prevention depends upon a population-based strategy that tackles the social and environmental causes of ill health, premature mortality, and disability, and not only individual risk factors and the clinical manifestation of disease -- symptoms and signs observed by physicians or felt by the patient.

Those of us who work in health and across many other sectors at the World Bank Group, as well as in coordination with WHO and other international agencies, now have an unprecedented opportunity to help countries design and introduce coherent, evidence-based, multisectoral policies and actions to push forward the strategy of health promotion and disease prevention to deal with NCDs (and road traffic injuries). In doing so, World Bank Group teams can become major contributors to the improvement of the health status and the well-being of populations, and hence to end poverty and reduce inequalities, across the world in years to come.

Follow the World Bank health team on Twitter: [@worldbankhealth](https://twitter.com/worldbankhealth) [3]

Ending the Communicable and Non-communicable Disease Divide in Africa

SUBMITTED BY [PATRICIO V. MARQUEZ](#) ON TUE, 07/10/2012



Co-authored with Jill Farrington

The 2011 UN Summit on Non-communicable Diseases (NCDs) elevated the importance of NCDs as a pressing global health challenge. While this recognition was long overdue, are we at risk of establishing a new vertical program, in direct competition for scarce funding with existing communicable diseases control programs and health system strengthening initiatives?

If we pay close attention to available evidence, that should not be the case. The health situation in sub-Saharan Africa nicely illustrates this point, as we have learned from an extensive review of the literature.

While the focus in this region has been on communicable diseases and maternal, perinatal and nutritional causes of morbidity and mortality, less attention has been paid to the extent to which these conditions contribute to the growing NCD burden and to potential common intervention strategies. Indeed the biggest increase in NCD deaths globally in the next decade is expected in Africa, where they are likely to become the leading cause of death by 2030.

The same underlying social conditions, such as poverty and insanitary environments, are associated with the onset of both communicable and non-communicable diseases, and there are close relationships between these disease groups in terms of causation, co-morbidity, and care.

Frequently, both communicable diseases and NCDs co-exist in the same individual, and one can increase the risk or impact of the other. Some infections cause or are related to NCDs; for example cervical cancer, a leading killer of women in Africa, is caused by the human papilloma virus. Treatment of communicable diseases can also increase NCD risk: Antiretroviral drug therapy for HIV is saving lives, but as the HIV-infected population ages, cardiovascular disease prevalence and mortality increase significantly as shown in recent research (Tseng, ZH et al. 2012). NCDs or their risk factors can also increase the risk of infection; for example, smoking and diabetes each increase the risk of tuberculosis, and co-morbidity of tuberculosis and diabetes can worsen outcomes for both diseases.

Many maternal illnesses and behaviors affect children, including tobacco use, anemia, and over- and under-nutrition. Gestational diabetes is a strong predictor of future illness, both of the mother, who may develop diabetes and cardiovascular diseases later in life, and the child, who also becomes at risk. Poor maternal nutrition before

and during pregnancy together with smoking tobacco during pregnancy contribute to poor intrauterine growth, resulting in low birth weight which in turn predisposes to NCD risk later in life. Thus, the current poverty of much of sub-Saharan Africa may result in an epidemic of cardiovascular diseases in middle age for those who survive. The problem is compounded by HIV/AIDS: for example, low birth weight and malnutrition are more frequent in HIV-infected children.

The potential risks of setting up yet another vertical program in resource-constrained countries such as those in Africa need to be acknowledged and overcome, with integration and resource-sharing where feasible in the health system.

For example, at the primary care level, maternal and child health programs could include combined interventions to alleviate malnutrition and reduce smoking in pregnant women, increase the uptake of breastfeeding, monitor birth weight, promote healthy nutrition in families, identify and manage hypertension and diabetes in pregnancy, and promote smoke-free homes.

Collaboration with reproductive and sexual health programs could promote the use of condoms and safe sex practices and raise awareness of early signs and symptoms of breast and cervical cancer.

The scope of immunization programs could be expanded to include not only vaccine-preventable diseases among children but also improved access to HPV vaccines to prevent cervical cancer and Hepatitis B vaccination to prevent liver cancer. Models already exist for collaboration with tuberculosis control programs to benefit patients with non-infectious respiratory symptoms in primary care facilities, such as asthma and chronic obstructive pulmonary disease. Screening for hypertension and elevated blood sugar levels can be administered among people diagnosed with HIV infection.

Much illness and inefficient resource use can be avoided in sub-Saharan Africa – diseases and disabilities are frequently preventable – but comprehensive and systematic approaches need to be applied which build on existing resources and experience and capitalize on the inter-linkages between communicable diseases, NCDs, maternal and child health, and socio-economic development.

Although the largest share of costs of disease are borne by the individual concerned, Governments could play a catalytic role in tackling the main NCD risk factors as part of an integrated health agenda, since (i) there are substantial societal costs resulting from second-hand smoke and alcohol-induced injuries and fatalities; (ii) people are not always fully aware of the health (and other) consequences of unhealthy lifestyle choices such as smoking, alcohol abuse, physical inactivity, and poor diet; they may also be misled by information provided by the food, alcohol, and tobacco industries; and (iii) children and adolescents (and even adults) tend not to take into account the future consequences of their current choices, irrespective of whether they are informed about them.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Non-Communicable Diseases and the Post-2015 Development Agenda



Submitted by Patricio V. Marquez On Mon, 03/11/2013



A couple weeks ago, I had the opportunity to participate in the launching of *The Lancet's* fourth series on non-communicable disease ^[1] (NCDs) and development. This was a well-attended event chaired by the Dean of the London School of Hygiene and Tropical Medicine, Prof. Peter Piot.

It was clear by the presentations and discussion that there is a growing consensus at the international level on the need to identify mechanisms for global action to tackle NCDs. Indeed, as noted in a statement of support sent on behalf of U.K. Prime Minister David Cameron, “NCDs affect the poorest people most as prevention, detection and treatment services are often out of reach. Our focus on health in developing countries is to support improvement in the provision of accessible and good quality, basic health services for the poor so that countries can identify and address their own health priorities including NCDs.”

The aim of the new series is to contribute to discussions on setting a clear path for countrywide implementation of NCD plans in the post-Millennium Development Goal (MDG) era, toward a unified goal of '25 by 25'—reducing NCD mortality worldwide by 2025. The series builds on previous *Lancet* Series (2010, 2007, 2005), and on the high-level United Nations NCD meeting convened in New York in September 2011.

The papers in the series cover a range of points of view, addressing: 1) the importance of embedding NCDs into post-2015 MDG strategy, essential if the '25 by 25' target is to be achieved; 2) NCD countrywide/ step-wise approaches

including planning, implementation, accountability, and the importance of a National NCD Commission to monitor progress; 3) reducing health inequalities; 4) addressing the negative effects of 'unhealthy food and drink commodities'; and 5) the importance of scaling up access to vital medicines, including wider availability of affordable generic drugs.

Perhaps one of the key contributions of the new series to the ongoing discussion on “what to do” to effectively tackle NCDs is an article on how to improve responsiveness of health systems to NCDs while avoiding the false dichotomy of controlling communicable and non-communicable disease separately. Indeed, the Lancet article by Atun et al makes a strong case and provides examples on how the significant HIV and TB investments made over the last decade to strengthen health systems in developing countries offer opportunities to integrate NCD prevention and control with HIV and other programs.

As I’ve argued elsewhere in relation to the situation in Africa, the double burden of communicable and non-communicable disease challenges policymakers and service providers to adopt/adapt innovative approaches that use existing resources to make health systems more effective in dealing with the growing reality of individuals afflicted by multiple chronic conditions and complex symptoms. Let’s not forget, for example, that the scaling up of antiretroviral drug treatment has made HIV/AIDS a manageable chronic condition or that the comorbidity of TB and diabetes in the same individual can worsen outcomes for both diseases.

As we move into the post-2015 development agenda, building upon accumulated scientific evidence and country experiences, it is imperative that rather than concentrating on specific diseases, future global health efforts be centered around building institutions and systems that offer both more equitable access to quality services to address the health needs of the population, and financial protection in cases of premature death, ill health and disability.

This rethinking of goals and approaches is doable if we do not lose sight that the end result should be the improvement of health conditions that impede human development. Indeed, as Helen Clark, United Nations Development Programme Administrator, eloquently stated in the keynote address at the launch of *The Lancet* series, “NCDs, and the illnesses and suffering associated with them, stand in the way of people’s aspirations, freedoms, and capabilities to lead lives they value – that is, they stand in the way of realizing the core objective of human development.”

Follow the World Bank health team on Twitter: [@wordbankhealth](https://twitter.com/wordbankhealth) ^[2]

Published on *Nasikiliza* (<http://blogs.worldbank.org/nasikiliza>)

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Preventing Maternal Mortality - A Yardstick for Social Justice



Submitted by Patricio V. Marquez On Tue, 10/01/2013

I was glad to read the [announcement](#) ^[1] made by World Bank President, Dr. Jim Kim, at the start of this year's UN General Assembly meetings, about the Bank's projected financing support through the end of 2015 to help developing countries reach the [Millennium Development Goals](#) ^[2] (MDGs) for women and children's health. As we move toward the culmination of the MDGs in 2015 and beyond, preventing maternal and child deaths should be seen by all government delegations and their partners in the international development community as a clear yardstick to measure their commitment for creating more just and inclusive societies.

But as evidence has shown across the globe, to effectively address the insidiousness of this challenge, a broad multi-sectoral paradigm for action is needed. In some countries, particularly in resource-poor settings and among certain population groups, there are social and cultural norms that need to be better understood to deal with myths and misconceptions surrounding pregnancy, childbirth and proper care of the newborn. There are also geographical barriers, as in rural communities high in the Andean mountains of my native Ecuador, or in the Caucasus mountain range in Georgia and Azerbaijan, where the poor state of roads in a challenging terrain, or the unavailability of transport to a health facility, contribute to preventable maternal deaths.

Since in most cases pregnancy complications cannot be predicted, a well-run health system organized around a care continuum—from prevention and diagnosis to care and rehabilitation, and without the hindrance of financial barriers to those in need, is an essential mechanism that needs to be in place to deal in a timely fashion with direct obstetric complications. Such complications cause more than 60% of maternal deaths and include hemorrhage, hypertensive disease, sepsis/infection, and obstructed labor.

What happens inside a health facility is of utmost importance in saving lives, beginning with the availability of trained and motivated staff to render needed services around the clock and essential drugs and blood products; adherence to basic quality standards, such as mandatory hand washing by doctors or nurses before patient examination; administration of safe blood transfusion in case of hemorrhage; and proper management of obstetrical and newborn complications such as eclampsia, asphyxia, and sepsis, which are often fatal if not promptly treated.

The power of modern technologies can also be harnessed to improve maternal and child health. As I recently learned in Ghana, an initiative by Mobile Technology for Community Health (MoTeCH) and the Grameen Foundation, piloted in the Upper East Region and now being replicated in the Central, Greater Accra and Volta Regions, is allowing women with limited literacy skills to be informed in the local language about the “do's and don'ts” in pregnancy and childbirth. Women also receive reminders on clinical appointments, due dates, and required medication and immunization through their mobile phone.

This technology enables women, their partners and families, to recognize the signs of life-threatening complications during pregnancy and empowers them to seek immediate care. Other applications allow community midwives and nurses to provide rapid response and care and to follow up with health service defaulters in the community.

Building upon agreements made at the 2012 London Summit on Family Planning, and follow-on discussions expected in Addis Ababa in November 2013, added impetus should be given to ensure well-funded and accessible voluntary family planning services as another essential but integrated tool to reduce unwanted pregnancies, unsafe abortions, and the risk of maternal death.

It is clear, as noted by Dr. Kim and colleagues in a [recent article](#) ^[3] in The Lancet, that the end of extreme poverty will require sustained investments to improve health care delivery. It should be obvious to all of us working in global development that a critical step toward that goal should be the revamping and acceleration of efforts to make maternal mortality a rare event, rather than a daily occurrence across the world. To paraphrase the great Nelson Mandela, the keener revelation of a society's soul is how it treats its women and children.

2.

The Changing Global Burden of Disease

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > What we learned about the Global Burden of Disease?

What we learned about the Global Burden of Disease?



Submitted by Patricio V. Marquez On Wed, 10/12/2016

co-authors: Melanie Walker

Kofi Annan, the former Secretary-General of the United Nations, observed that knowledge is power and information is liberating. Indeed, the collection, analysis and dissemination of data and information should not be seen only as an instrument of scientific inquiry but more importantly, as a critical tool for guiding the formulation and implementation of policies to address complex problems in society.

Last week at George Washington University in Washington, D.C., we had the opportunity to participate in the presentation of the findings of the Institute of Health Metrics and Evaluation's (IHME) Global Burden of Diseases, Injuries, and Risk Factors Study 2015 ^[1] (GBD). Published as part of a dedicated issue of *The Lancet*, the GBD provides a picture of population health dynamics across the world over the last 25 years. The evidence generated by the GBD on the basis of comparable health estimates by year, age, and sex for 249 causes from 195 countries and territories, represents an important “global public good” as it informs current and future health policy discussions around the world.

What are some of the key findings of the GBD 2015?

- Globally, **life expectancy at birth** has increased significantly from 61.7 years in 1980 to 71.8 years in 2015. It is particularly noteworthy that several countries in sub-Saharan Africa had large gains in life expectancy after years of high loss of life due to HIV/AIDS. These gains largely reflect increased access to diagnosis and treatment. Violence and conflict, however, contributed to rising mortality and stagnation and decline in life expectancy in some regions, such as the Middle East. This phenomenon was clearly observed in Syria, where male life expectancy dropped by 11.3 years to 62.5 years over the 2005-2015 period.
- Over the 1990-2015 period, **the world as a whole has been undergoing a health transition** (Fig. 1 below). Whereas total deaths and age-standardized death rates due to communicable (e.g., HIV/AIDS, malaria), maternal, neonatal, and nutritional conditions significantly declined, marked increases were recorded in total deaths and age-standardized death rates from non-communicable diseases (NCD). Vascular disease, cancers, and chronic respiratory diseases are the leading causes of NCD deaths; the relative importance of Alzheimer's disease and other dementias as a cause of death increased as well, reflecting the aging of the population. Age-standardized death rates from injuries declined, although interpersonal violence and armed conflicts claimed a higher number of lives in 2015.

Figure 1: Leading Causes of Global YLLs for both sexes, 1990, 2005, 2015



Source: The Lancet (2016, Volume 388, Number 10053).

- **Non-fatal outcomes of disease and injury detract from the ability of the world's population to live in full health.** As populations grow and increase in average age, the total burden of disability is rising quickly. As a result, the number of people living with sequelae of diseases and injuries is increasing. Between 2005-2015, NCDs account for 18 of the leading 20 causes of age-standardized years lived with disability (YLDs). GBD also confirms the large contribution of mental and substance use disorders to global disability, which raises the importance of achieving mental health parity in the provision of health and social services.
- **In terms of environmental, behavioral, occupational, and metabolic risk factors and their attributable burden of disease,** the GBD illustrates a health risk transition across the world. Attributable disability-adjusted life years declined for environmental risks such as unsafe water, sanitation, and hygiene, as well as household air pollution, micronutrient deficiencies, childhood undernutrition. These trends, which experienced a significant decline as countries develop, are driving the notable reduction in the relative importance of infectious diseases as leading causes of ill health and death. By contrast, some health risk factors are growing worse as countries develop contributing to the rising burden of NCDs. Globally, the leading risk factors are high systolic blood pressure, smoking, high blood sugar level, and high body-mass index. In some regions, alcohol and drug use as well as exposure to occupational risks and air pollution are also important risks.

Overall, the findings of GBD 2015 convey some good news, but they also point to emerging challenges as well as opportunities for action. In moving the global health agenda forward, an important message from the GBD that we should keep in mind is that development drives, but does not determine, the health status

of the population. As observed worldwide, more developed countries tend to be healthier than less developed ones, but countries are much healthier than expected given their level of development, such as Ethiopia, China, Cuba, and Spain.

For those engaged in policy dialogue, program design and implementation at the global, regional and country levels, the above message implies that the effective use of the wealth of data and information from GBD demands that we assess and try to understand the particular drivers of the observed trends in specific contexts. In doing so, we must keep in mind that a close relationship exists in cause, course, and outcome between communicable diseases, maternal, perinatal, and nutritional conditions, and NCDs--they are part of the same biological continuum. This reflects common underlying social conditions, such as poverty and unhealthy environments, and commonalities across disease groups in causation, co-morbidity, and care needs. Frequently, both communicable diseases and NCDs, or a combination of risk factors, co-exist in the same individual, and one can increase the risk or impact of the other, as happens for example with diabetes and tuberculosis. Similarly, factors like maternal health, the intra-uterine environment, and low birthweight can have long-term consequences for developing NCDs.

This inescapable reality reinforces the need for integrated approaches at the country level that address functions (prevention, treatment, and care) rather than disease categories. And given the multisectoral nature of health conditions, actions that reach beyond the health system, such as fiscal and regulatory policies, have to be essential components of an effective arsenal of interventions to improve health conditions globally.

Published on *Voices* (<http://blogs.worldbank.org/voices>)

[Home](#) > Income inequality and differential mortality: An ominous combination

Income inequality and differential mortality: An ominous combination



Submitted by Patricio V. Marquez On Wed, 05/04/2016



It is safe to argue that the issue of income and wealth inequality is nowadays at the center of political debate across the world. Leading intellectuals such as Thomas Piketty in his seminal work, “Capital in the Twenty-First Century,” and Joseph Stiglitz in “The Price of Inequality” have rigorously analyzed the evolution of this social phenomenon and argued that increased inequality and lack of opportunity are creating divided societies that are endangering the future of nations.

Those working in public [health](#) ^[1] have for years documented and discussed how low and decreasing incomes, decline in standards of living, and lack of or limited access health care and other essential services contribute to inequalities in health, manifested in a widening gap in life expectancy between the rich and the poor.

While the relationship between income and life expectancy is now well established, recent studies on the United States population yield new evidence that helps enhance our understanding of the characteristics of this phenomenon and provide insights for policy action.

A Brookings Institution report, “Later Retirement, Inequality in Old Age, and the Growing Gap in Longevity between Rich and Poor”^[2], has documented how increased earnings inequality over the last three decades, especially among men, has resulted in a concentration of longevity gains among the well-educated and those at the top of the income distribution.

The findings call into question policy proposals that advocate increasing the retirement age in line with increases in average life expectancy, as they may have large unintended distributional consequences (i.e. those in the top income brackets can expect to claim and enjoy for a longer period of time the benefits from Social Security and Medicare programs than those men and women in the bottom of the income distribution that tend to delay their retirement and have more physically demanding occupations or die prematurely).

A study in the Journal of the American Medical Association, “The Association between Income and Life Expectancy in the United States 2001-2014”^[3], also demonstrated that in the United States between 2001 and 2014, higher income was associated with greater longevity. Data from the study provided evidence of relationships between life expectancy and socioeconomic factors such as differences in access to medical care, environmental differences, adverse effects of inequality, and labor market conditions.

A key finding in the study is that most of the variation in life expectancy across geographical areas was observed to be related to differences in health behaviors, including smoking, obesity, and physical activity, and local area characteristics, such as existence of public policies that promote health — smoking bans and higher taxation rates for cigarettes, or greater funding for public services.

It should not surprise us that the above studies demonstrate anew that the way people live is directly related to their consequent risk of illness and premature death. The question for all of us is, what can be done to address the socioeconomic disparities in health and alter the pattern of increasing differential mortality?

For one, effective government policies are needed at the macro level since they affect wealth dynamics in a society. In particular, the enactment of progressive tax reform to mobilize domestic revenues for public investment and other public needs should be a priority policy goal, alongside efficient allocation and utilization of those resources. And, if we accept the fact that besides job loss, economic trauma among individuals and families is caused by ill health, premature mortality, and disability, the mobilization of additional domestic resources should be linked to supporting the progressive realization of universal health coverage^[4] (UHC).

Achieving UHC involves implementation of population-based strategies and interventions to deal with health risk factors at the societal level, such as tobacco taxation and bans on smoking^[5] in public places; measure to control alcohol and substance abuse; and road safety measures. It also means facilitating access to timely medical care and protecting the population from the impoverishing impact of high out-of-pocket expenditures in case of illness.

Additionally, improvements are needed in the design of public pension^[6] plans to prevent inequality among the aged due to changes in retirement patterns and differential rates of mortality, and ensure redistribution of wealth across population groups. The growing concentration of longevity and better health status among those at the top of the wealth and income pyramid in a society should not be our destiny.

Rather, let's accept, as Stiglitz advises us, that our vision should be of a "society where the gap between the have and the have-nots has been narrowed, where there is a sense of shared destiny, a common commitment to opportunity and fairness ... where we take seriously the Universal Declaration of Human Rights ^[7], which emphasizes the importance of not only civil rights but of economic rights."

And, I would add, the vision needs to include health rights for all as well.

3.

Bringing Mental Health Out of the Shadows

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Mental Health: Time for a Broader Agenda

Mental Health: Time for a Broader Agenda



Submitted by Patricio V. Marquez On Tue, 04/22/2014



Nowadays there is an awakening of interest in the international community to understand mental illness in its different manifestations and societal impact, and to identify ways to effectively deal with these often misunderstood, neglected and stigmatized conditions.

This is not a new phenomenon. Throughout history, mental illness has been the subject of different interpretations and approaches to treatment. In his seminal book, “Madness and Civilization: A History of Insanity in the Age of Reason,” French philosopher Michel Foucault examined the changing meaning of “madness” in different epochs and described how, in the mid-17th century, with the adoption of a conceptual distinction between rational and irrational behavior, those deemed “mad” began to be separated from society by confining them, along with other outcasts, in newly created institutions all over Europe.

Irrational behavior was seen as “moral error,” with individuals having freely chosen “unreason.” The “treatment” regimes of these new institutions were programs of punishment and reward aimed at causing these persons to reverse their “choice.”

At the end of the 18th century, with the creation of asylums – places devoted solely to the confinement of the “mad” for the protection of society– “madness” became a mental illness to be studied and cured under the supervision of medical doctors at an institutional setting.

Unfortunately, in the second decade of the 21st century, not much has changed in many countries regarding how society views and deals with mental illness. As noted in the World Health Organization (WHO)'s "Mental Health Action Plan 2013-2020 ^[1]," homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, and this tends to exacerbate their marginalization and vulnerability.

The time has come to accept that mental health is an integral part of health and societal well-being, particularly given the growing relative importance of mental and substance use disorders which are heavily influenced by socio-economic, biological and environmental factors, and which, as such, deserve sustained multisectoral action.

The 2010 Global Burden of Disease study ^[2] showed that mental and substance use disorders – including depression, anxiety, schizophrenia, and drug and alcohol abuse – are already the fifth-leading cause of overall disease burden, accounting for 7.4% of total years lost due to illness, disability and early death.

Since mental health issues cause the most disability in ages 9 through 29, they exert a strong negative effect on human capital development and productivity in a society. At the same time, more than 20% of adults aged 60 and over suffer from a mental or neurological disorder, a problem that stands to grow in magnitude with the aging of the global population. Mental disorders tend to be more acute and often unattended in post-conflict countries where vast segments of the population have lived through long periods of armed conflict and ethnic confrontations. Many have been the subject of harassment, sexual abuse and rape, incarceration, and torture.

WHO's "Mental Health Action Plan 2013-2020" highlights a number of evidence-based, intersectoral strategies and interventions to promote, protect and restore mental health, beyond the institutionalization approaches of the past that often confined people to oblivion. These include government-led policies, investments, and programmatic actions, coupled with the active participation of private sector businesses and civil society to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles.

These interventions span the life cycle and include early childhood interventions, such as pre-school psychosocial, health and nutrition activities that target disadvantaged populations; socio-economic empowerment of women to help overcome gender inequality; and social support for elderly to alleviate the consequences of dementia.

The Action Plan also recommends mental health interventions in the workplace, including support to help overcome stress caused by work-family imbalances and substance abuse disorders; violence prevention programs, including domestic violence; fiscal and regulatory measures such as taxation of alcoholic beverages and restriction of their availability and marketing; social protection for the poor; anti-discrimination laws and campaigns; and promotion of the rights, opportunities and care of individuals with mental disorders.

The global movement toward universal health coverage by 2030, advocated by World Bank President Dr. Jim Kim and WHO Director-General Dr. Margaret Chan during the 2014 IMF/World Bank Spring Meetings, will also be catalytic to effectively implement mental health care and treatment policies and programs as part of comprehensive and integrated efforts to facilitate access to quality medical and social care services.

UHC efforts can help to address community-level needs of persons with defined mental disorders and offer financial protection by covering mental health and substance use disorder services, including medicines, under health insurance and other risk-pooling arrangements. This was recently implemented in the United States under the Affordable Care Act, and is proposed in Ghana under Mental Health Act 846.

The World Bank, as a multisectoral institution, has a major role to play in supporting national and international agencies to implement the WHO Mental Health Action Plan approved by governments at the 2013 World Health Assembly.

In particular, Bank support could be critical to help adapt the Action Plan to specific national circumstances and to offer “entry points” to advance healthy population initiatives during the preparation of country partnership strategies, conduct needs assessments, and in the design of policies, programs and projects in different sectors.

In moving forward with a broad social agenda to address mental health needs, we need to be guided by Thomas Jefferson’s wise words: “Happiness is not being pained in body or troubled in mind.”

Follow the World Bank health team on Twitter: [@worldbankhealth](https://twitter.com/worldbankhealth) ^[3]

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > “The zero hour” for mental health

“The zero hour” for mental health



Submitted by Tim Evans On Mon, 05/04/2015

co-authors: Patricio V. Marquez, Shekhar Saxena



At times, many of us have felt a sense of loss or detachment from our families, friends and regular routines. We also have experienced nervousness and anxiety about changes in our personal and professional lives, as well as real or imagined fears and worries that have distracted, confused and agitated us.

While these episodes tend to be transitory for most of us, since they are a normal part of human life, for millions of people across the world, frequent and severe bouts of depression and anxiety are a debilitating daily burden that interfere with family, career, and social responsibilities. They can lead to alcohol or drug abuse or other self-destructive behaviors, which increase a sense of isolation and magnify feelings of sadness, loss, anger or frustration. Sometimes, death by suicide is an unfortunate outcome.

These mental disorders can also be triggered when massive social dislocations occur—driven by economic crises, such as the financial crisis of 2008; civil conflicts in places like Central America, Africa and Asia; epidemics, such as Ebola in Guinea, Liberia and Sierra Leone; or earthquakes, such as the recent one in Nepal. Even after economic growth returns and unemployment drops, after peace settlements are reached, after we eventually reach zero Ebola cases, after the dead are mourned, and

after the rebuilding of countries gets under way, there is long-term damage left behind in the social fabric of affected communities and mental well-being of individuals.

The social costs of mental and substance use disorders -- including depression, anxiety, schizophrenia, and drug and alcohol abuse--are enormous. They are the fifth-leading cause of overall global disease burden, accounting for 7.4% of total years lost ^[1] due to disability and early death. And estimates from a World Economic Forum study ^[2] show that the lost economic output due to the cumulative global impact of mental disorders will top \$16 trillion, or more than 1% of the global GDP, over the next 20 years.

Are countries prepared to deal with this often “invisible” and often-ignored malady? The simple answer is: no.

In the second decade of the 21st century, not much has changed in many countries regarding how society views and deals with mental illness. Despite its enormous social burden, mental disorders continue to be driven into the shadows by the ever-present reality of stigma, prejudice, fear of disclosing an affliction because a job may be lost, social standing ruined, or simply because health and social support services at the community level are not available or are out of reach for the afflicted and their families.

And some countries are still using 17th century tactics to “protect society”: confining and abandoning the “mad” in asylums or psychiatric hospitals, often for life, which compound the negative impact of mental illnesses on these individuals and on society as a whole.

In spite of these challenges, there is a growing impatience across the world to begin a new era in which mental health moves from the periphery to the center of the global health agenda and into the larger development context. Knowledge exists to guide this effort: As highlighted in WHO’s Mental Health Action Plan 2013-2020 ^[3], approved by member states, there are evidence-based, intersectoral strategies and interventions to promote, protect and restore mental health, beyond the institutionalization approaches of the past. Properly implemented, these interventions represent “best buys” for any society, with massive returns in terms of health and economic gains

If we are going to fully embrace and support the progressive realization of universal health coverage ^[4], we must work to ensure that prevention, treatment and care services for mental health disorders at the community level, along with psychosocial support mechanisms, are integral parts of accessible service delivery platforms and covered under financial protection arrangements. We must also advocate for and identify “entry points” across sectors to help tackle the social and economic factors that contribute to the onset and perpetuation of mental health disorders.

We, as part of an international, multi-institutional, working group, coordinated by the distinguished Harvard University professor, Arthur Kleinman, have begun to discuss ways to jump start society-wide efforts to address the mental health challenge. To this end, World Bank Group President Jim Yong Kim and Margaret Chan, the Director-General of the World Health Organization, will co-host a major event on mental health in Spring 2016.

As we move forward with this task, we will be guided by the belief that the agonies of mental health problems that distort people’s lives, family bonds and communities, and that impose a heavy economic and social burden, can be dealt with effectively if there is political commitment, broad social engagement, and international support to make mental health an integral part of health and societal well-being across the globe.

Roberto lunes, Senior Health Economist, World Bank Group, and Melanie Mayhew, Communications Officer, World Bank Group, also contributed to this post.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Shining a light on mental illness: An “invisible disability”

Shining a light on mental illness: An “invisible disability”



Submitted by Patricio V. Marquez On Wed, 12/02/2015

The poster for the International Day of Persons with Disabilities 2015 features a blue background with a white diagonal stripe. The United Nations logo is in the top right corner. The text '3 December' is in blue, and 'International Day of Persons with Disabilities' is in large red letters. Below this, 'Themes for 2015' are listed: 'inclusive and accessible cities • improving data and statistics • invisible disabilities'. The '2030 Agenda for Sustainable Development' is also mentioned. A word cloud in the center includes terms like 'take action', 'disability-inclusion', 'women with disabilities', 'promote dignity', 'organize forums', 'develop social policies', 'social integration', 'children with disabilities', 'accessible healthcare', 'data collection', 'end stigma and stereotyping', 'understanding disability', 'mobilize action', 'plan events', 'mainstream disability', 'ensure equality', 'inclusive education', 'advocate human rights', 'empowerment', and 'awareness-raising'. On the right, the 'Sustainable Development Goals' logo is visible, along with the text 'Be informed! Get involved!' and the website 'www.un.org/disability' and email 'enable@un.org'. The bottom left corner has the 'Accessible United Nations' logo.

This year's International Day of Persons with Disabilities ^[1], observed December 3, takes as its theme: “Inclusion matters: Access and Empowerment for People of all Abilities.” Under this umbrella, the U.N. and other international agencies urge inclusion of persons with “invisible disabilities” in society and in development efforts.

This call is long overdue; persons with mental and psychosocial disabilities represent a significant proportion of the world's population with special needs. The World Health Organization (WHO) estimates that millions of people have mental disorders, and that one in four people globally will experience a mental disorder in their lifetime. Moreover, almost one million people die each year due to suicide, which is the third leading cause of death among young people. According to several recent reports, suicide has surpassed maternal mortality as the leading cause of death among girls aged 15-19 years globally.

Aside from facing entrenched stigma and discrimination – and physical and sexual abuse in homes, hospitals, prisons, or as homeless people -- persons affected by mental disorders are excluded from social, economic and political activities.

When I was a student in the early 1980s working at St. Elizabeths Hospital in Washington, D.C., I had the opportunity to witness first-hand the plight of those “excluded and marginalized” from society due to mental disorders. At that time, one of the programs run by the hospital, which opened in 1855 as the first psychiatric hospital in the United States, provided care for mentally handicapped refugees and immigrants—both those admitted due to acute need for psychiatric care and those adjudicated to be criminally insane. Here, I helped deal with the “extreme of behaviors” experienced by “catatonic” patients who were confined to locked wards and monitored around-the-clock by security guards.

These patients included those who were not able to speak, move or respond, or appeared to be in a daze; and those that were overexcited or hyperactive, mimicking sounds or movements around them. I also experienced the joy of seeing some of these patients recuperate as a result of drug therapy and psychosocial support that helped manage their symptoms and start a process of supervised re-integration into the community. This often meant being discharged to a “halfway” house--a residence for persons after release from institutionalization for mental disorders.

We need to be clear, however, and accept the reality that ill mental health is not only limited to persons with severe mental disorders confined to psychiatric hospitals. Ill mental health is a widespread but often “invisible” phenomenon. Many of us or our parents, partners, sons and daughters, have felt a sense of loss or detachment from families, friends and regular routines. We also have experienced nervousness and anxiety about changes in our personal and professional lives, as well as real or imagined fears and worries that have distracted, confused and agitated us.

While these episodes tend to be transitory for most of us, some of these conditions force us to take frequent breaks from our work, or we need time off or a leave of absence because we are stressed and depressed, or because the medication that we are taking to alleviate a disorder makes it difficult to get up early in the morning or concentrate at work. And on occasion, because of these disorders, some fall into alcoholism and drug use, further aggravating “fear attacks” or sense of alienation from loved ones and daily routines.

And, apart from personal consequences, the social and economic costs of ill mental health are staggeringly high, measured in terms of potential labor supply losses, high rates of unemployment, disability costs, high rates of absenteeism and reduced productivity at work.

This year’s observance of the International Day of Persons with Disabilities offers a good opportunity to shine a light on some of the myths surrounding mental illness, particularly at the workplace where we tend to spend most of our waking hours. Indeed, a recent OECD report ^[2] provides evidence that most people with mental disorders are in work and many more want to work.

It is estimated that the employment rate of people with a mental disorder is around 55-70%, or 10-15 percentage points lower than for people without a mental disorder, on average across the OECD-member countries. Many more people with a mental disorder want to work but cannot find a job; as a result, they are typically twice as likely to be unemployed as people with no such disorder.

In moving forward the disability-inclusive development agenda, including the gradual realization of universal health coverage, we need to start paying particular attention to common mental disorders of workers, the unemployed, and their families, and not only on the provision of services for people with a severe mental disorder. This would require, as suggested by the OECD report, dedicated effort to integrate health, employment and social services, moving away from silo-thinking and developing strong coordination and integration of policies and services.

Action is also needed to inform, train and empower actors outside the traditional mental health sphere, such as school authorities, managers, general practitioners, and in particular public employment services caseworkers, to facilitate labor market re-integration of people with mental health disorders, given the frequent unawareness and non-disclosure of mental disorders. Strengthened data collection and monitoring systems are critical to guide policy decisions and programmatic action on the basis of evidence and better understanding of the different characteristics and outcomes of ill mental health.

It is time to open our eyes to make this “invisible disability” visible! We at the World Bank Group, in partnership with other organizations, can contribute to advancing the mental health agenda ^[3] globally on the basis of cross-cutting and multidisciplinary approaches that build social resilience.

In doing so, paraphrasing Judith Rodin ^[4], President of The Rockefeller Foundation, individuals, communities, organizations and systems will have the capacity to assist affected and vulnerable populations to bounce back from the shock and disruption of ill mental health and offer them opportunities to reintegrate, participate and contribute to community life.

Follow the World Bank health team on Twitter: @WBG_Health ^[5]

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Live, Love, Laugh: A message from Deepika Padukone

Live, Love, Laugh: A message from Deepika Padukone



Submitted by Deepika Padukone On Wed, 04/13/2016

Editor's note: Deepika shared the message below to be read at today's [Out of the Shadows](#) ^[1] event, which aims to make mental health a global development priority. We have reposted the message in full below.

Let me begin by saying how deeply sorry I am that I couldn't make it today. As you know, Mental Health is a cause very close to my heart and it would have meant so much to me to be here in person.

I would like to congratulate the World Bank and the World Health Organisation for taking the initiative to organise this conference 'Out of the Shadows – Making mental health a global development priority.'

In February of 2014, I woke up one morning with a sick, pit-ish feeling in my stomach. I felt low, empty and directionless. I couldn't understand what was happening to me. Waking up every morning was becoming a struggle.

It was only after I started seeing a counsellor that I realized I was suffering from anxiety and depression. It took a lot of convincing from my parents, to see a psychiatrist, and from then on it was a combination of counselling and medication over a couple of months that helped me recover. 2014 was the toughest year of my life!

As I began to read about and understand my condition, I realized that there were millions of people just like me. The WHO estimates that 350-400 million people across the world suffer from a range of Mental Health issues.

So on New Year's Day 2015 I decided to take my struggle to the world with the hope that this would encourage others like me to break through the stigma and reach out for help.

In March 2015, I made a decision to set up a foundation that would work towards spreading awareness, reducing the stigma and changing the way the world looks at Mental Health.

On October 10th, World Mental Health Day, we launched The Live Love Laugh Foundation.

This year The Live Love Laugh Foundations main focus is on conducting awareness programs in schools, creating a sensitization program for general physicians and launching a public media campaign on mental health.

Mental Health Issues are now assuming the scale of an epidemic and we truly need to work together to bring mental health out of the shadows and into the light and make it an urgent priority for governments across the world!

I hope very much that together we succeed in this critical mission of making mental health a global priority!

Published on *Investing in Health* (<https://blogs.worldbank.org/health>)

[Home](#) > Lessons from OECD countries: mental health is critical for human capital development

Lessons from OECD countries: mental health is critical for human capital development



Submitted by Patricio V. Marquez On Fri, 10/26/2018

co-authors: Emily Hewlett



October 11, 2018 - BALI, INDONESIA. 2018 IMF / World Bank Group Annual Meetings. Human Capital Summit 2018: A Global Call to Action. Photo: Grant Ellis / World Bank

At the World Bank Group (WBG)-International Monetary Fund Annual Meetings earlier this month in Bali, Indonesia, WBG President Dr. Jim Kim posed a critical question ^[1]: “What will it take to promote economic growth and help lift people out of poverty everywhere in the world...How will they reach their ambitions in an increasingly complex world?”

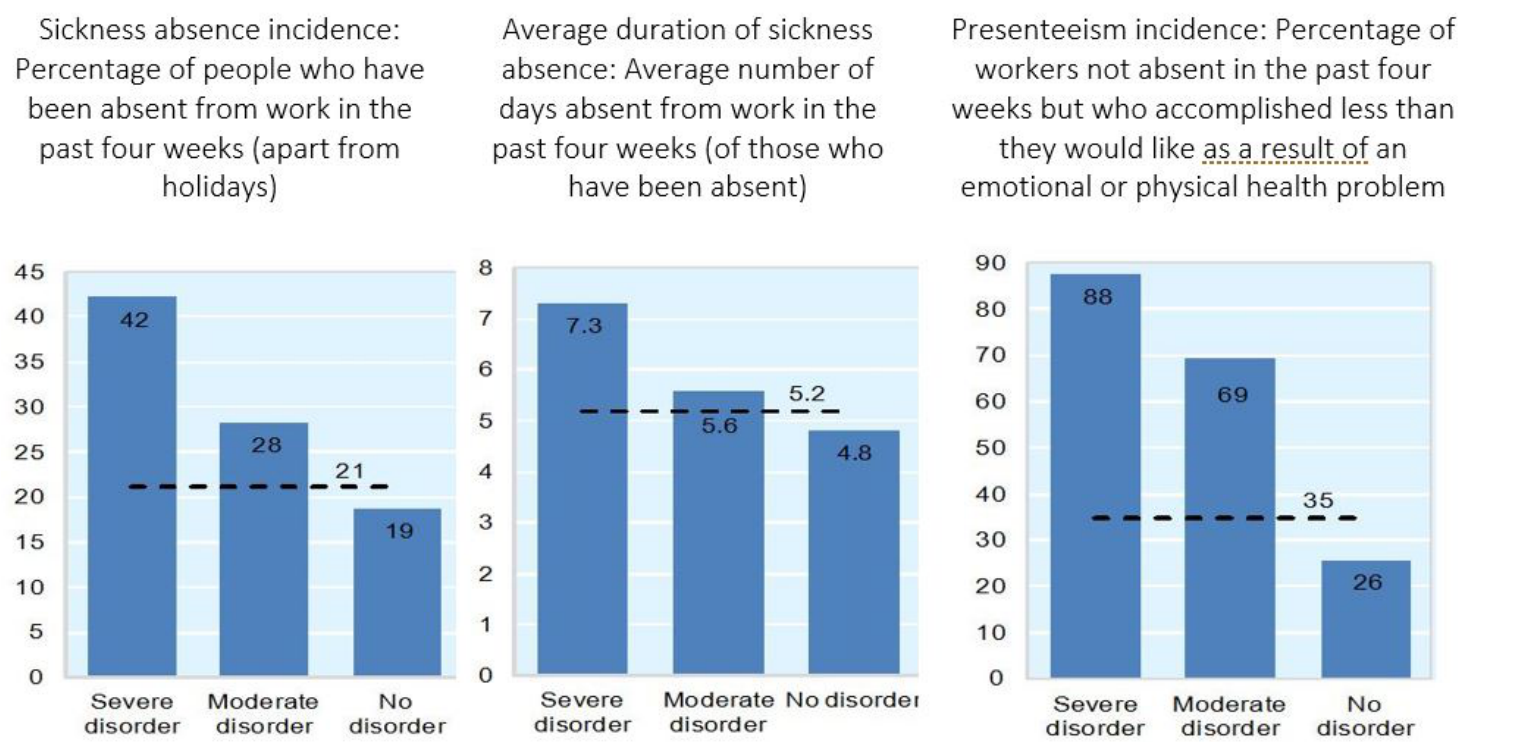
The key, President Kim noted, is for countries to make investments in people – ensuring that people accumulate the health, knowledge and skills needed to realize their full potential and that they can put those skills to use across the economy. In response, the WBG launched the Human Capital Project, ^[2] an effort to accelerate scaled and smarter investments in people around the world, and a Human Capital Index to measure the current and potential productivity of a country’s people.

As the same time as the Bali Annual Meetings, we were in London at the Global Mental Health Ministerial Summit ^[3], hosted by the U.K. Government and the Organization for Economic Co-operation and Development (OECD) with the support of the World Health Organization, making the case that investing in mental health is a critical but often overlooked investment in individual potential, human capital accumulation and economic success. Sadly, due to widespread global inaction, there is still limited or no access to integrated mental health services in most countries, which leaves mental health services under-resourced and creates a major problem for accessing appropriate care. Stigma and discrimination only compound the problem.

Yet this approach is myopic. A growing body of evidence shows that the social and economic losses related to unattended mental conditions, including substance use disorders, are staggering. In the world’s most advanced economies – the 36 OECD countries – mental ill health affects an estimated 20 percent of the working-age population [4] at any time, and its direct and indirect economic costs are estimated to account for about 3.5 percent of gross domestic product (GDP), equivalent to US\$1.7 billion in 2017.

In the wealthy OECD countries, which spend on average 9 percent of GDP on health care, the high economic cost associated with mental conditions is largely driven not by mental health care expenditure, but by lost productivity in the working-age population (see Figure 1). Indeed, people suffering from mental ill health are less productive at work, are more likely to be out sick from work and when they are out sick are more likely to be absent for a longer period. Around 30 to 40 percent of all sickness and disability caseloads in OECD countries are related to mental health problems, according to a 2015 OECD report [5].

Figure 1: Measures of productivity loss: Sickness absence incidence and duration and proportion of workers accomplishing less than they would like because of a health problem, 2010

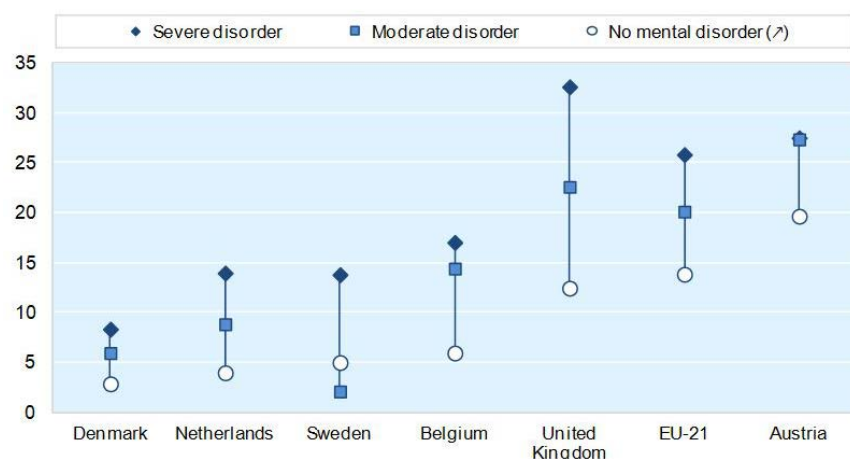


Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*.

While most people with a mental illness do work, people living with mild-to-moderate mental disorders, such as anxiety or depression, are twice as likely to become unemployed [6]. Premature mortality is another tragic driver of lost human potential and productivity; in the typical OECD country, people with bipolar disorder or schizophrenia, for example, have a mortality rate 4 to 6 times higher [7] than the general population.

To effectively tackle the lost human capital from mental health conditions, it is imperative that countries turn their attention to preventing and addressing mental health conditions earlier in the life course. The economic costs of mental ill health begin before individuals enter the workforce, as mental health problems typically have their onset in childhood or adolescence, accounting for the most significant disease burden amongst children and young people [8]. However, often there isn't appropriate care and treatment [8] at this life stage, or it doesn't occur right away. This can have a lasting impact, as children and young people with mental ill health are more likely to stop full-time education early and have poorer educational outcomes (see Figure 2).

Figure 2: Percentage of people who stopped full-time education before age 15, by severity of mental disorder, 2010



Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*.

If countries want to improve their relative ranking in the WBG's Human Capital Index, they must start investing seriously in integrated programs to promote mental well-being and prevent and treat mental ill health ^[9] in communities, maternal and child health and nutrition programs, in schools, in their health systems, in prisons and in the workplace. It's also value-for-money, as it is much more effective to take action while people are still in school or the workplace ^[10] than wait until they have dropped out from schools, the labor market or fall into a revolving door of homelessness and incarceration ^[11].

There are examples of progress on this front. In 2015 employment and health ministers from the OECD countries signed up to show their support for an integrated policy approach ^[12], agreeing that more policies were needed to support the mental health of young people, develop an employment-oriented mental health care system, build better workplace policies with employer support mechanisms and incentives and make benefits and employment services fit for claimants with mental health problems. We need more of this. As we argued in London, an integrated, cross-sectoral approach, rather than intervention silos, is a must. Inaction on mental health cannot be a challenge for health systems to tackle alone -- communities, schools, employers and society as a whole must all be on board.

Published on *Voices* (<https://blogs.worldbank.org/voices>)

[Home](#) > Resilient youth seize opportunities, build their future

Resilient youth seize opportunities, build their future



Submitted by Liviane Urquiza On Sat, 08/12/2017

Also available in: Français | العربية | Español | 中文



A portrait of Blessing Joe, 10 year old Ebola survivor, Liberia. 2016. © Dominic Chavez/World Bank

She was seven when she survived a night of horror. Her home in Nigeria was marked for an attack that night for belonging to the ‘wrong’ ethnic group. My friend and the rest of her family were destined to be killed.

But she survived. Her neighbors who noticed the mark alerted them and helped them escape at a time when their other neighbors were being executed and even burned alive. That night, my friend saw a man die in very violent circumstances. The shock was so intense that she could not speak for two weeks.

Over two decades later, she is no longer in danger and has now built a new life. As we sat listening to her mother retell the sequence of events that happened that night, my friend realized she had forgotten most of it. Now as an adult, living in the U.S. with her family, it was safe to recollect and recount the details of what had occurred.

Fortunately, memory is selective, and it allowed my friend to forget the painful experience until she was ready to cope with it. I find it fascinating to see how the human mind helps us survive intense trauma or adversity transforming the experiences into assets that aids us thrive in future. “What doesn’t kill you makes you stronger,” and how better can I describe her resilience?

Seizing Opportunity

According to a recently published [Yale University study](#) ^[1] on young victims of the Syrian conflict, the reconstruction path of young people diverges depending on their capacity for resilience. The most resilient, will be able to seize opportunities such as pursuing studies. It also found that higher levels of resilience were associated with less stress and fewer [mental health](#) ^[2] problems.

So how do we get these youngsters to be resilient?



[Countries and communities' resilience relies on the resilience of their youth.](#) ^[3] When these young men and women are able to develop their potential, prospects are improving for all, and poverty rates are falling.

According to the [UN](#) ^[4], there were 1.2 billion youth aged 15-24 years globally in 2015, accounting for one out of every six people worldwide. [These numbers are growing](#) ^[5], particularly in developing countries, where, in many places, young people represent [30 percent of the population](#) ^[6].

The choices young people make determine the size, health and prosperity of the world's future population. Youth have many pressing needs. Nonetheless, we need a stronger and more coherent economic argument to invest in youth.

From [natural disasters](#) ^[7] to economic shocks, overcrowding cities or health crisis, the World Bank Group helps countries anticipate and mitigate risks to which their economic and social development may be exposed. In other words, it helps them become more *resilient*.



[Precariousness of children and adolescents is an important marker of a country's vulnerability.](#) ^[8] A precarious generation will find it harder to rebound in the event of a shock. Hence the importance of developing solutions so as not to abandon the potential of youth.

Frustrated aspirations in youth can lead to creating problems in societies, and countries won't be able to compete in the global economy if they don't invest. Collecting more and better data on adolescents is also critical for making these investments. The lack of reliable information on the effects of many investments in youth is the most important information gap.

For youth growing up while dealing with hardship, one might think, it basically comes down to watching all your dreams being wiped out, but that might be a major oversight. Let's not forget that human beings have an extraordinary power: a unique ability to "get over" things, to be *resilient*.

Liviane Urquiza is the co-editor of [worldbank.org/youth](#) ^[9].

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Entrepreneurs in fragile, conflict and violence-affected countries face unique mental health challenges



Submitted by Priyam Saraf On Wed, 10/24/2018

co-authors: John Speakman



(C) World Bank

Fragility, conflict and violence (FCV) have become some of the most pressing threats to economic development. Over 2 billion people live in FCV countries [1], and it is expected that by 2030 nearly 50 to 60 percent of the world's poorest people will live in areas affected by conflict. This can pose major socioeconomic challenges [2], including a reduction of gross domestic product growth by 2 percentage points per year and driving youth to join rebellions due to conflict-driven unemployment.

One way FCV countries work to reduce the risk of violence and help build resilience is by creating economic opportunities through jobs, which can decrease poverty, increase productivity and build social cohesion. In FCV countries, the responsibility for creating these critical jobs in the private sector falls on the shoulders of entrepreneurs of formal small and medium enterprises (SMEs), as well as SMEs in the informal sector.

However, working in a FCV context can have far-reaching consequences on the well-being and productivity of entrepreneurs. The unusually high demands and stress of operating in FCV-affected areas can result in mental health challenges such as depression and anxiety among SME entrepreneurs, according to a recently published World Bank Group (WBG) report [3]. To address this, the report explores potentially scalable interventions, such as cognitive behavioral therapy (CBT) [4] trainings that can be implemented in low-capacity contexts and measured for impact. CBT is based on the concept that our thoughts, feelings, physical sensations and actions are interconnected, and the way individuals perceive a situation is more closely connected to their reaction than the situation itself. CBT helps an individual identify unhelpful thought patterns to improve how they feel, and hence, behave.

Even in non-FCV environments stress can be problematic for entrepreneurs. Whereas low to moderate levels of stress can be a positive trigger for the performance of entrepreneurs, chronic stress is harmful for their mental well-being and performance in the long run. Compared to large firms, SME owners and managers lack diversified capital, stable sources of income and/or delegation opportunities. This can leave them more prone to stress-driven depression, anxiety and other mental health conditions.

These entrepreneurial stressors are exacerbated in FCV environments. SME entrepreneurs routinely work with significantly higher levels of uncertainty and risk, so decisions can start to represent tough choices. Every difficult decision imposes a cognitive cost, sapping energy and attention, and depleting working memory. Over time, this can affect an entrepreneur's productivity through reduced attention to detail, lower motivational capabilities, which then discourages employees through a mood contagion effect [5], and an increased tendency to display counterproductive work behavior(s) [6] resulting in more angry outbursts.

One place where this can be seen is in Khyber Pakhtunkhwa (KP) and Federally Administered Tribal Areas (FATA) of Pakistan. Conflict over three decades has resulted in a significant decline in SME performance here, which now ranks among the poorest regions in the country. A recent rapid needs assessment of SME entrepreneurs in KP and FATA by the WBG, with the Human Development Research Foundation, found various adverse symptoms, such as "agitated mood, disturbances in diet and sleep, low self-esteem, nervousness, loss of interest and inability to concentrate on work." These symptoms were directly attributable to conflict-related stressors, such as "fears about the safety of their loved ones, as well as flashbacks and thoughts of traumatic experiences."

While there is a dearth of systematic studies looking at the link between fragility and mental health outcomes for entrepreneurs, and even less on its impact on business outcomes, literature [3] from cognitive psychology and public health shows that with the proper set of CBT interventions, significant positive changes can be observed in FCV environments.

In addition to our recent report, to add to this body of evidence and explore potential impacts on entrepreneurs, the WBG is conducting a small pilot study to measure whether CBT trainings can improve mental health and business outcomes among SME entrepreneurs in KP/FATA. Baseline data from the study shows that more than 35 percent of the randomized sample of 234 entrepreneurs qualify for clinical case levels of depression, confirming what we find in the literature. However, according to the baseline data, few people recognized these challenges as mental health problems that need specific management, even though a significant share report a derailment of their business results due to health outcomes.

The study results looking at the impact of CBT on mental health outcomes will be released next year, but early data points to both male and female entrepreneurs being unique at-risk groups. Entrepreneurs score high on "self-efficacy," which indicates confidence in their ability to get things done, but this trait might also make them less likely to seek help. Cultural norms play a role too, making it less likely that both men and women will seek help. Whereas men are expected to be "strong and macho," a lack of freedom and traditional social structures prevent women from accessing support. Since these interventions tend to be inexpensive, financial constraints do not appear to be a concern.

Even with these early results, there are two potential policy considerations that could help address these issues. First, the economic rehabilitation of a population exposed to a humanitarian crisis must include interventions to reduce mental health challenges and build resilience. This implies including mental health interventions as part of the basket of technical support provided to SMEs, which includes access to finance, infrastructure and technology extension services, and technical training. Second, we should consider expanding "occupational health" policies in FVC contexts to include at-risk job creators. This would encourage leaders and managers of job-creating firms who function in high levels of uncertainty to seek support, helping to decrease the negative impacts of the high stress experienced in FCV environments.


Published on *End Poverty in South Asia* (<https://blogs.worldbank.org/endpovertyinsouthasia>)

[Home](#) > The unheard voices of women caregivers for people with mental illness

The unheard voices of women caregivers for people with mental illness



Submitted by Varalakshmi Vemuru On Tue, 05/16/2017


co-authors: Samhita Kumar  [1]




SHG meeting of people with mental illness and caregivers. (Photo: TNMHP)

Thirty-year old Vijaya (name changed) spent 10 years of her life not talking to anybody. Her parents were daily wage laborers, scraping together a sparse living in India's southern state of Tamil Nadu. Unaware of any treatment, and afraid of being stigmatized or shunned by their community, they did not disclose their daughter's illness to anyone. Instead, Vijaya suffered in silence, confined to the house, and hidden from public view.

It was only when the Tamil Nadu government's [Mental Health Program](#) [2] (TNMHP) reached out to their community that Vijaya's life underwent a dramatic change. After six months of working with the program's community facilitators, Vijaya's parents took her for treatment, and within a year, the young woman began interacting with others more frequently.

[Poor mental health places a huge burden on individuals, families, and society.](#)  [3] From developed countries to emerging market economies, mental disability – ranging from common mental disorders such as depression to severe mental illnesses and retardation – has profound impacts on people's economic and social well-being.

As cited in "[Out of the Shadows: Making mental health a global development priority](#) [4]," in 2010 alone, depression cost an estimated US\$800 billion in lost economic output.  [5] What's worse, these costs are expected to double by 2030.

Unfortunately, in India, as in many other countries, there is a great deal of social stigma attached to mental disability. Families with mental health issues often don't seek treatment because they are afraid that once people get to know, they will be shamed or lose social status, or the marriage prospects of their family members will diminish. Riddled with misconceptions, most people turn to traditional healing methods for relief, or go in for harmful treatment practices.

To address a variety of mental health issues, which are often swept under the carpet, the TNMHP, supported by the World Bank with PHRD funds from 2012 to 2016, helped create awareness among communities in the state and counselled families to change their way of thinking.

The project's community-based interventions enabled women and girls to overcome their hesitation in seeking treatment. They reached young people through telemedicine and skype, ensured that diagnosis and medication were accessible, and provided both caregivers and those suffering from mental illness with livelihood support and social rehabilitation.

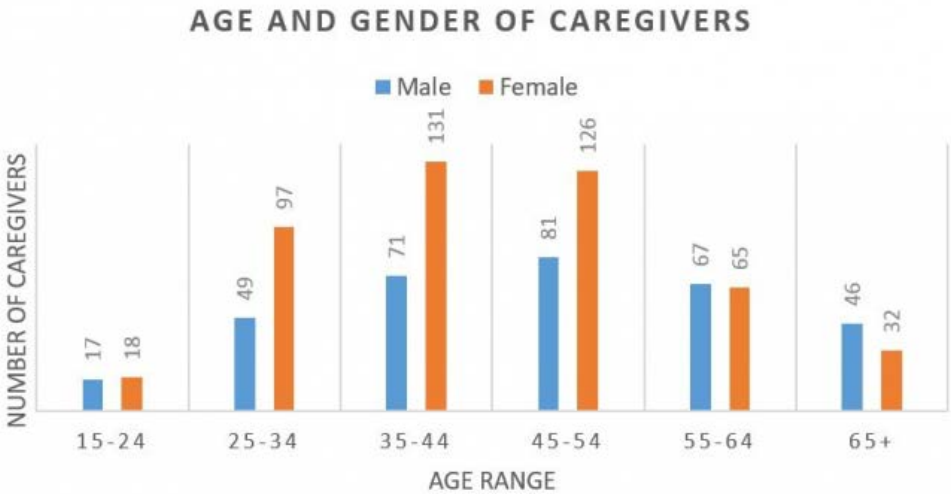


Like Vijaya, 32-year old Muthu and his elderly mother benefited under the program. While Muthu received medical treatment, his caregiver mother was helped to get a job under the national wage guarantee program. Meanwhile Raja, a 45-year-old man suffering from depression, received counselling, together with a loan that helped him clear his debt and build his business anew.

- [About this series](#) ^[6]
- [More blog posts](#) ^[7]

Reaching caregivers

Very often, the onus of caring for a person with mental illness falls on the young women of the house. ^[8] be they daughters or daughters-in-law. A recent evaluation of the program shows that most caregivers range between 25 and 54 years of age, with women accounting for more than half of those responsible for the duty. Usually, the caregivers have to forego jobs that could otherwise have brought in desperately needed wages, in addition to the mental strain that accompanies caregiving.



To ease some of the burden on these young women, the program knitted them into self-help groups to create appropriate networks and foster peer support. It also brought medical camps closer to the villages so that families could access treatment easily, without incurring additional expenses. In addition, it helped beneficiary families – most of whom worked as daily wage laborers – to build their skills to augment family incomes.

Importantly, it supported day-care centres for people with mental disabilities, enabling caregivers to pursue a livelihood. These centers provide people with mental disabilities with counselling, skills training and livelihood opportunities. In sum, the project has helped people with mental disabilities to access proper treatment, while also paying heed to the hitherto unheard voices of their women caregivers, enabling them to earn a living while supporting their loved ones.

**Names used here are not the real names of beneficiaries.*

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > On World Health Day, why I'm choosing to talk about depression

On World Health Day, why I'm choosing to talk about depression



Submitted by Patricio V. Marquez On Thu, 04/06/2017

Also available in: [Español](#) ^[1] | [Français](#) ^[2]

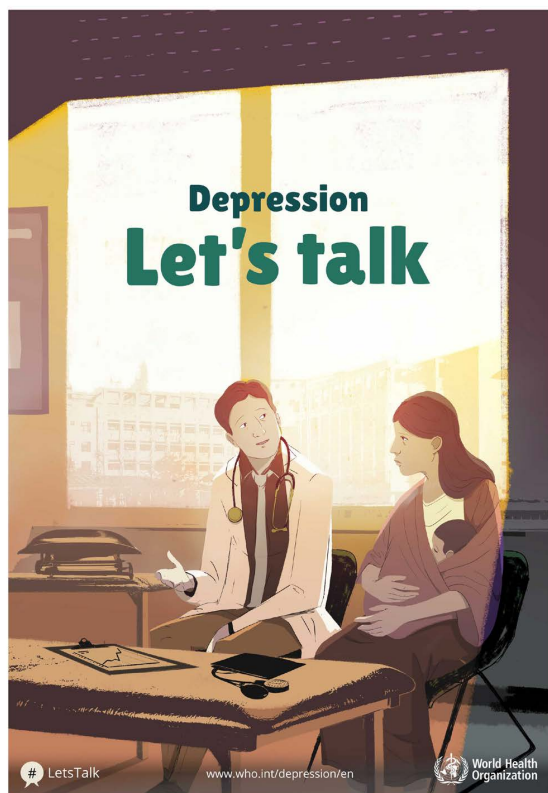


photo: WHO

This year's [World Health Day](#) ^[3] carries a particular significance for me and for many others. The theme, “Depression: Let’s Talk,” shines a light upon a problem that oftentimes remains hidden in a dark corner of our minds, trapping us in a painful agony of sadness, loss of interest, and fear.

While I have been blessed with good physical health, at different points in my life, I have succumbed many times to a sense of loss and detachment that has made me feel weak and incapable of facing the day, the week, or much less the future. These episodes often appeared in periods of transition, such as moving from high school to university, or times when I was separated from family, or when I experienced the loss of my father while living alone in Africa. With a telephone call, or later in life, when I was able to connect using Skype or FaceTime, I managed to reach out to loved ones, share the anguish that I felt at the

moment, and little by little, with words of reassurance that everything was going to be all right and that things will get better the next day, I was able to step out of those invisible walls that were encircling me, casting a heavy shadow. These feelings prevented me from appreciating the recharging feeling of a good walk or from marveling at the rebirth of trees and the multitude of colors that appear in the early Spring.

Let me confess: those periods were and are difficult to face. They are not easy to handle. When I listened to "This Depression", a song by Bruce Springsteen, I not only learned about his long struggle with depression, but I concluded that the lyrics of the song describe with great clarity familiar feelings:

"Baby, I've been down
But never this down
I've been lost
But never this lost
This is my confession
I need your heart
In this depression
I need your heart
Baby, I've been low
But never this low
I've had my faith shaken
But never hopeless"

You may ask, why I am trying to exorcise my mental demons in a public blog? The answer is simple. All of us who have faced this very tangible reality know well that it is not something that people like to talk about because it is uncomfortable or because most people do not know what it's like to experience these conditions. Unlike the manifestation of physical diseases, a depressed mood, loss of interest and enjoyment, poor concentration, constant anxiety, and reduced energy are typically not visible to others. As a result, the easy path for the affected is to retreat, to close up, to hide the anguish of not feeling well because we do not want to be embarrassed to be seen as weak or perceived as falling apart.

While melancholy and sadness are conveyed with dignified clarity by the guitar riffs of blues masters like the legendary B. B. King, or starkly portrayed in the paintings of Pablo Picasso's "blue period", for many of us, feeling down, sad, or anxious represent transitory moments that can be managed with some effort and the help of loved ones and friends, or if required, with professional advice or some form of therapy. Unfortunately, for those without access to health services or social support, severe depression and anxiety often translates into a life of misery, compounded by alcoholism and drug dependency, living with the terror of being discovered, fearing unemployment or loss of family—a situation that puts them at the margins of society and that could tragically end in suicide.

Indeed, as documented in a recent report by the World Health Organization (WHO), depressive and anxiety disorders are highly common across countries, impacting the mood or feelings of affected persons, with debilitating symptoms that range in severity (from mild to severe) and duration (from months to years) and that extract a terribly high social toll. These disorders, which are diagnosable health conditions, are distinct from feelings of sadness, stress, or fear that anyone can experience from time to time in their lives. Globally, over 300 million people are estimated to suffer from depression, equivalent to 4.3% of the world's population. More than 80% of this non-fatal disease burden occurred in low- and middle-income countries.

None of us is immune to these conditions, as they can and do affect people of all ages, from all walks of life. However, the risk of becoming afflicted by severe depression and anxiety is increased by poverty, unemployment, death of loved ones, a relationship break-up, physical illness, conflict, forcible displacement, refugee status, social dislocation, and crime and violence.

On this World Health Day, we will do well in expressing our compassion and understanding for those affected by these mental maladies that harm the health, functioning, and well-being of people. In the pursuit of universal health coverage and the sustainable development goals, we cannot forget that the achievement of mental health parity in health care and social services provision should be a fundamental measure of effective health and social policy, planning, organization, and financial protection arrangements for people in need across the world.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Maternal Depression and Stunted Children: An Avoidable Reality

Maternal Depression and Stunted Children: An Avoidable Reality



Submitted by Patricio V. Marquez On Thu, 09/06/2018

co-authors: Sheila Dutta



Accumulated scientific evidence ^[1] shows that proper nutrition and stimulation in utero and during early childhood benefit physical and mental well-being later in life and contribute to the development of children's cognitive and socioemotional skills. Yet, a critical but often overlooked fact in policy design and program development across the world is the association between maternal depression and childhood stunting -- the impaired growth and development measured by low height-for-age.

The human, social and economic toll imposed by lack of attention to mental illness and substance use disorders across the world is enormous. It is estimated ^[2] that at least 10% of the world's population is affected and that 20% of children and adolescents suffer from some type of mental disorder. In fact, according to WHO data, mental illness account for 30% of non-fatal disease burden worldwide and 10% of overall disease burden, including death and disability. Recent estimates indicate that about 23% of 667 million children under the age of 5 worldwide are stunted, and an estimated 45% of deaths of children under age 5 are linked to malnutrition ^[3].

Depressive disorders during pregnancy and the post-natal period are common in both developed and developing countries, impacting negatively both mothers and children. And in some countries, suicide (which is frequently caused by mental disorders) is a leading cause of death among women aged 15 to 49 ^[4]. Diverse factors, including poverty, gender discrimination, marital conflict, domestic violence, crime, post-traumatic stress, substance use disorders, and lack of control over economic resources, contribute to the onset of mental illness, which can cause functional impairment at a time when the mother is performing

tasks vital to an infant's growth and development. Research suggests that maternal depression is associated with compromised parenting behavior, nonresponsive caregiving practices, and a lower likelihood or shorter duration of breastfeeding.

Data from different countries [5] show that unattended maternal mental illness has a negative impact on infant and young child growth, development and care, having serious health implications in terms of physical, cognitive and emotional well-being during crucial stages of the life span, such as the first 1000 days and early childhood. For example, a study in Northern Ghana [6] found that children of depressed mothers are more likely to be stunted compared to children of non-depressed mothers. A recent study in Mexico [7] estimated the prevalence of depression among mothers at 21.4%, with a negative impact on children at different socioeconomic groups. In low-income households, depression was associated with higher risk of never being breastfed, health problems, acute respiratory disease, injuries requiring child hospitalization, and moderate or severe food insecurity, while in medium- or high-socioeconomic households, depression was associated with higher risk of never attending a developmental check-up, and moderate or severe food insecurity.

The risk for emotional and behavioral problems is also known to be high among children of depressed mothers. A comprehensive literature set documenting the effects of maternal depression on both the psychological and physical development of children, evidence that children who experience maternal depression early in life may experience lasting effects on their brain architecture and persistent disruptions of their stress response systems, with implications for their ability to learn as well as for their own later physical and mental health [8].

These findings suggest that prevention of maternal depression could lead to reduction of negative childhood health and development outcomes.

Since some of the benefits from improved human capital accrue beyond the generation in which the investments are made, we feel that it is imperative that a concerted, multisectoral response be supported, not only to raise public awareness and political commitment about mental health as an often overlooked and stigmatized issue, but also to support the integration of mental health and psychosocial support services as part of reproductive and child health services and early childhood programs, benefiting both mothers and children. Interventions could include routine screening for and early treatment of prenatal and postnatal depression, and psychotherapy for groups to improve adoption of nutrition-related behaviors to reduce stunting.

We also feel that this proposition is doable and highly cost-effective. A study prepared for the 2016 WBG/WHO global mental health conference [9] showed that the returns on investment in mental health treatment at the community level can be substantial with benefit-to-cost ratios ranging between 2.3-3.0 to 1 when economic benefits are considered and 3.3-5.7 to 1 when social returns are included.

In addition, recent studies [10] indicate that mental illness can be affordably treated in developing countries. Varied interventions, such as health care and social support, group therapy or home visits, which are often delivered by lay community workers and auxiliary personnel at primary care settings and at the community level, have led to a demonstrated reduction in maternal depressive symptoms in a diverse range of countries, including China, Brazil, Jamaica, Pakistan, Peru, South Africa and Uganda.

We feel, therefore, that to transform lives and communities, it is imperative that country governments with the support of the international community fund the sustainable scale up of mental health prevention and treatment as part of integrated health and social services delivery platforms, including humanitarian and development programs for addressing the needs of displaced people and refugees. If this is done, not only mothers' well-being and children's healthy development would be promoted, but society at large stands to reap the benefits of closing the human capital gap, enhancing a country's productivity and competitiveness, and the resulting future prosperity of countries

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Healthy women are the cornerstone of healthy societies

Healthy women are the cornerstone of healthy societies



Submitted by Patricio V. Marquez On Thu, 01/12/2017

co-authors: Melanie Walker



Photo: Ivelina Taushanova / World Bank

On a recent road trip over the holidays, one of us had a good chat with his college-aged daughter about her views on gender. She was quite adamant in rejecting arguments voiced by some people about “innate intellectual differences” between males and females. She views these arguments as sexism that ignores the fact that there are women who are not getting the same opportunities as men because they are subject to cultural norms that limit their potential.

We not only agree with her views but also know that healthy women are at the core of healthy societies. The health of women is not, however, innate to any society. Development experience has shown that deliberate policies and programmatic strategies aimed at nurturing women’s health and well-being across the life cycle are vital for realizing the full potential of women and girls.

The World Bank Group Gender Strategy [1], which builds on the 2012 World Development Report

(WDR) on “^[2]Gender Equality and Development^[2],” makes the point that while some women may face fewer disadvantages now than in the past, major gaps remain. One significant gap is excess female mortality, which could be avoided with better access to quality health care services, particularly during pregnancy and child delivery. Early detection and treatment for conditions such as cervical cancer help increase survival rates as many women are diagnosed only after the disease is in an advanced stage, leading to higher case fatality. As noted by the US CDC ^[3], since the human papillomavirus (HPV) is the main cause of cervical cancer, vaccination among school-aged girls is another critical intervention.

Social conditions and cultural norms that limit women’s access to health services, education, and economic opportunities are at the root of women’s health disparities and exacerbate the feminization of poverty as measured by the higher percentage of female -headed households who are poor. The prevalence of gender-based violence (e.g., in the midst of conflict situations, human trafficking, and domestic violence) is another often hidden determinant of women’s excess morbidity and mortality.

Research has shown that many maternal illnesses and lifestyle behaviors also affect children, amplifying their negative impact on society. For example, tobacco and alcohol use, anemia, over-nutrition, and under-nutrition all have potential long-term consequences on children. Gestational diabetes is a strong predictor of future health, both of the mother, who may develop diabetes and cardiovascular diseases (CVD) later in life, and the child, who has increased risk of developing Type II diabetes later in life. Poor maternal nutrition before and during pregnancy, as well as tobacco and alcohol use during pregnancy, contribute to poor intrauterine growth, resulting in low birth weight (LBW), which in turn predisposes the child to metabolic disorders and risk of non-communicable chronic diseases (NCDs) later in life. These problems are compounded by HIV and malaria. For example, LBW and malnutrition are more frequent in HIV-infected children, and malaria infection during pregnancy is a common cause of anemia and LBW.

Findings from new research also provide evidence about the impact that the well-being of women has on the intergenerational propagation of good physical and mental health. The findings ^[4]published in late 2016 indicate that pregnancy is associated with substantial changes in brain areas of pregnant women that are responsible for social cognition and the ability to understand the thoughts and intentions of others and that they may help intensify the bonding between mothers and their babies, and hence, the survival and healthy development of children.

Supporting access to effective interventions such as reducing malnutrition, preventing anemia, and improving access to essential health services, including effective contraception, are not only important for ensuring women’s well-being but also for improving nutrition in the early years of children and as important preventive measures for arresting the explosive growth of NCDs worldwide as noted above. The promotion of breastfeeding – which protects against diarrhea, respiratory infections, and obesity -- also helps prevent NCDs and protects against infection, apart from its nutritional benefits. Screening for gestational diabetes and screening for and prevention of malaria, HIV, and tuberculosis could also be part of an integrated antenatal care program with multiple benefits. And in conflict-and post-conflict contexts, programs targeting displaced populations and refugees are found to maximize their impact by combining nutrition, maternal mental health, and psychosocial stimulation interventions that address the symptoms of post-traumatic stress linked to exposure to extreme violence. Such integrated interventions have been shown to reduce the disabling impact of post-traumatic stress on mothers’ ability to nurse and feed their children.

Investing in women’s education is another critical contributor to child health. Again, research data ^[5] highlight the strong correlation between mother’s primary school completion and better infant health (as measured by incidence of very low birth weight) and child health (as measured by height-for-age and weight-for-age), even after controlling for many potential confounding factors. The data also shows that mother’s primary school completion leads to earlier preventive care initiation and reduces smoking. An

assessment of increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009 [6] showed that half the reduction in child mortality over the past 40 years can be attributed to the better education of women--that is, for every one-year increase in the average education of reproductive-age women, a country experienced a 9.5% reduction in child deaths. Economic empowerment of women is also transgenerational, women who have the dignity of a roof above their heads and food on their tables make better choices not just for themselves but for their families, including their children.

In short, it should be clear that addressing the root causes of ill health, premature mortality, and disability among women, and enhancing women's voice and agency to deal with limiting, and in some cases, oppressive, social and cultural norms and gender-based violence that impede the health and human capacity development of women is a cross-sectoral development priority. Policies that help turn the tide against the feminization of poverty and toward enabling women to lead lives of sustainable economic advancement and self-reliance will at the same time improve the health and mental well-being of future generations, and contribute to ensure that development is socially and economically inclusive.

VOICES

Tackling gender inequality through investments in health equity


SUBMITTED BY KRISTALINA GEORGIEVA  ON THU, 11/08/2018


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Still today, in almost all societies around the world, women are less well-off than men.  Women are still paid less than men; they are less represented in business, politics and decision-making. Their life chances remain overwhelmingly less promising than those of men.

This inequality hurts us all. The world would be 20% better off if women were paid the same as men.  Delaying early marriage in the developing world by just a few years would add more than \$500 billion to annual global economic output by 2030.

But this is more than a problem of lost income. For women and girls in poor countries, it cuts life short before it can flourish.

Today, 830 women will die from complications related to pregnancy or childbirth. 🐦 This month, 450,000 children under the age of five will die. This year, 151 million children will have their education and employment opportunities limited due to stunting. If current trends continue, 150 million more girls will be married by 2030.

Clearly, we need to accelerate progress so that no woman or child is left behind.

We need to allow women to time and space pregnancies as they choose, support safe deliveries, breastfeeding, and other basic services that are critical for health and nutrition. 🐦 Good health leads to better educational attainment, and full participation in the labor force.

Bold new thinking is required to transform the lives of women, children and adolescents. It begins by making their lives our first priority in development. It means alignment between international donors and national governments to ramp up funding, and a global commitment to life-saving and health-enhancing services for every woman, child and adolescent.

The good news is there is a funding facility dedicated to improving health and life chances for women and children in the poorest countries. 🐦 In 27 countries, it is already strengthening the delivery of quality services across pregnancy, birth, early years and adolescence by incentivizing governments prioritize spending on health and nutrition. This week, Heads of State and Ministers from across the world met in Oslo to decide on the future of the Global Financing Facility (GFF), with the aim to scale things up and tackle head-on the terrible effects of gender inequality on health.

In response, ten new investors—Burkina Faso, Côte d'Ivoire, Denmark, the European Commission, Germany, Japan, Laerdal Global Health, the Netherlands, Qatar and an anonymous donor—announced in Oslo that they were contributing more than US\$1 billion to the GFF, which the World Bank will link to an additional US\$7.5 billion in IDA/IBRD resources for women, children and adolescents' health and nutrition.


The early results of the GFF are promising, and a recent study in The BMJ Global Health showed that just \$US2.6 billion of GFF financing could catalyze up to US\$75 billion of additional money by 2030—70% of which will come from increases in countries' own domestic resources. It also showed that as many as 35 million lives could be saved by 2030 if global health investments contributing to maternal and child mortality continue to grow at current rates.

We point to three reasons for the early success of the GFF. First, it puts countries in the driver's seat and rallies financial and implementation support towards their priorities, based on what they know will work on the ground. Second, it helps governments harness financing from multiple sources towards a single set of goals. This includes governments' own resources, so they have skin in the game.

Finally, the GFF has a strong focus on results so health ministers can make the case for a greater share of the overall domestic budget. The government of Cameroon is a case in point. Since working with the GFF, it has committed to dramatically increase its national budget allocation for primary and secondary healthcare, from 8% in 2017 to 20% by 2020. This 150% expansion in government financing for health will help to accelerate access to safe and quality services for mothers and children.

And in the northeast of Nigeria, where there has been long-lasting conflict, GFF support has helped to re-establish maternal, newborn and child health and nutrition services. By linking funding to health results, local governments are making rapid progress—including increasing births attended by (midwives) health professionals from an estimated 5% coverage to 40%.

At the GFF Replenishment I spoke up to end health inequality for women, children and adolescents. I stood with the Bill & Melinda Gates Foundation, the governments of Norway and Burkina Faso, country health ministers and hundreds of other partners. The US\$1 billion we raised, and the new partners we welcomed, this week are major steps. I encourage other partners to join us in our quest to realize the full potential of every woman, child and adolescent.

Together we can invest in the empowerment of women and children in poor countries and strengthen countries' capacity to finance the health of their people sufficiently and sustainably. 

Together, we can make unprecedented progress towards a fairer and more prosperous world.

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Mental Health in Prisons: How to Overcome the Punishment Paradigm?



Submitted by Patricio V. Marquez On Thu, 09/27/2018

Early this year, I was part of a panel [at The Kennedy Forum's Fourth Annual Meeting on mental health](#) ^[1]. This year's meeting focused on the theme, "Bending Towards Justice: A Summit for Mental Health Equity" to address the question Dr. Martin Luther King Jr. posed fifty years ago – 'where do we go from here?'.

I was deeply touched by statements and testimonies from people from all walks of life, but what impressed me the most was the discussion about the "veil of oblivion" surrounding the dire conditions of mentally ill people in jails and prisons.

[A 2016 report by the University of London](#) ^[2] estimated that worldwide more than 10.3 million people are held in penal institutions at any given time and more than 30 million people pass through prisons each year. Country data show that as many as half the people in jails and prisons have a mental disorder. For example, as shown in Alisa Roth's gripping new book "*[Insane](#)*" ^[3], although the overall number of people behind bars in the United States has decreased in recent years, the proportion of prisoners with mental illness has continued to go up. Data in the book indicate that in Michigan about 50% of people in county jails have a mental illness, and nearly 25% in state prisons do. The mental health crisis is more pronounced among women prisoners: one study by the US Bureau of Justice Statistics found that 75% of women incarcerated in jails and prisons had a mental illness, as compared to just over 60% of men.

As observed by Roth, jails and prisons have become de facto "warehouses for the mentally ill", who tend to be among the most disadvantaged members of society. Moreover, when the mentally ill end up in the criminal justice system, they tend to fare worse than others and are susceptible to medical neglect and abuse, since ultimately the mission of jails and prisons is punishment, not medical care. And not all the effects occur inside the criminal justice system; many people with mental illness cycle back and forth between jail or prison and living in the community, and have an elevated risk of all-cause mortality, including suicide, both while in custody and soon after release.

This situation, eloquently argued by one of my fellow panelists at the Kennedy Forum, Mark Holden, senior vice president and general counsel for Koch Industries, shows that the way criminal justice system deals with mental illness is profoundly broken, leading not only to tremendous anguish and suffering among mentally ill people locked away behind bars, but to high rates of recidivism once prisoners go back into the community, compounding social and economic costs of untreated mental illness and substance-use disorders.

What to do?

A critical challenge faced in most countries is to overcome the “punishment paradigm” often found in penal systems by focusing on addressing the mental health needs of prisoners and bringing about their recovery. This requires a concerted effort to overcome the criminalization of mental illness by offering comprehensive physical and mental health services during incarceration and to support transition to community life after prisoners are released. Effective service pathways include screening for mental illness and substance-use disorders to ensure case identification at reception and at other critical times; prison-based care and treatment services; referral to specialized facilities for prisoners with serious mental illness; and release planning to ensure continuity of care across health care and social services providers to reduce recidivism post release. If this is done, in combination with education, skills development, and social support, the penal environment will offer true recovery opportunities for the incarcerated.

A recent article in the Financial Times ^[4] describes other innovative approaches being implemented with good results. These are “judge-led therapy programs”, which offer non-violent offenders with substance use disorders the opportunity to avoid jail, by agreeing to intensive mentoring and support. A good example ^[5] of such programs is the one spearheaded by Steve Leifman, a Florida judge, that follows a simple premise: when a person with a mental illness or a substance use disorder is arrested for a nonviolent misdemeanor, he or she can be steered toward treatment rather than criminal court. The vast majority opt for treatment, where they are connected with housing and other services. Recidivism is low, patients get the support they need, and the prison system saves significant funds.

Countries will do well by adopting prison system reforms, that include effective mental health treatment, care, and rehabilitation programs that focus on the whole person – body, brain, and spirit. If this is done, individual lives could be improved and freed from discrimination and stigma and with the opportunity to overcome health challenges and realize second chances in pursuit of a fulfilling life; families reunited; jobs gained; dignity regained; and overall society wellbeing enhanced by addressing the needs of the mentally ill and those with substance use disorders. A glimmer of hope? Yes, but one that is possible if political commitment and public and private efforts push forward this agenda as a moral imperative in society.

Published on *Voices* (<http://blogs.worldbank.org/voices>)

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Invisible wounds: Mental health among displaced people and refugees



Submitted by Patricio V. Marquez On Tue, 10/11/2016





The plight of forcibly displaced people, who are fleeing conflict and violence, is best summed up by the lyrics of the plaintive 1970 classic by Argentine troubadour Facundo Cabral: ***"No soy de aquí ni soy de allá"*** ("I'm not from here nor there").

Those lyrics convey both the sense of uprootedness felt by those displaced from their native lands and habitual routines, and the feeling of "otherness," emotional detachment, and powerlessness when relocated to foreign surroundings and societies, which in some cases, are unwelcoming to outsiders.

While not a new historical phenomenon, the current crisis of forced displacement is posing serious humanitarian and development challenges across the world which we cannot ignore given their scale and complexity. As documented in a recent World Bank report, ***"Forcibly Displaced: Toward a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts,"*** about 65 million people, or one percent of the world's population, live in forced displacement and extreme poverty. As differing from economic migrants that move in search of better opportunities and those affected by natural disasters, the forcibly displaced, both refugees and asylum-seekers (about 24 million people), and internally displaced persons (about 41 million people), are fleeing conflict and violence. And let's not forget that host communities are also affected by economic and social disruptions caused by inflows of displaced people.

As advocated in the report, reducing vulnerabilities of the forcibly displaced during a crisis and helping rebuild their lives in the medium term, while mitigating the impact on host communities, can be managed by the international community. It requires adequate effort and effective collective action to support economic activity, job creation, and social cohesion, as well as to strengthen and expand health and education services, and housing and environmental services.



When designing these programs, we have to be conscious that displaced people not only have lost much of their assets and risk the depletion of human and social capital, but also have experienced traumatic events, including witnessing the killing of loved ones, family separation, abandonment of children and the elderly, and being subjected to torture, rape, and other forms of violence that leave deep and lasting mental scars. Unlike physical wounds and losses, conditions such as post-traumatic stress disorders, depression and anxiety, and traumatic brain injuries, which affect mood, thoughts, and behavior, are often “invisible” to the eye or simply persist unrecognized, unacknowledged, or ignored in humanitarian and development assistance programs, undermining efforts to help rebuild and sustain the lives of displaced populations.

What can we do? As was advocated at the global mental health event organized by the World Bank Group and World Health Organization at the 2016 WBG/IMF Spring Meetings, a collaborative response is required to tackle mental health as a development challenge. Such a response would involve multidisciplinary approaches that integrate health services at the community level, in schools, and in the workplace to explicitly address the mental health and psychosocial needs, including alcohol and other drug use problems, of displaced people and host communities. It would also include innovative social protection and employment schemes that facilitate the reintegration of affected persons into social and economic activities, such as done under Canada’s RISE Asset Development, which provides seed capital and lends at low-interest rates to people with a history of mental health and addiction challenges.

It is time to stop treating mental and substance use disorders differently than other health conditions. After all, these are disorders of the brain, an equally important organ in the human body as the heart, liver, or the lungs. In moving forward, a firm commitment is needed from national and international actors to champion mental health parity in the provision of health and social services, as part of dedicated development support and assistance programs. We must help displaced people and refugees overcome their vulnerabilities, build mental resilience, and take full advantage of poverty reduction programs, economic opportunities, and legal protection, particularly to deal with widespread stigma and discrimination.

I am optimistic that recent attention to this issue will lead to increased commitments, funding, and implementation of required multi-sectoral action to address the needs of displaced people and refugees. In doing so, let's not forget the words of António Guterres, recently nominated to serve as secretary general of the United Nations, who observed, that "while every refugee's story is different and their anguish personal, they all share a common thread of uncommon courage – the courage not only to survive, but to persevere and rebuild their shattered lives."

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Mental health services in situations of conflict, fragility and violence: What to do?



Submitted by Patricio V. Marquez On Tue, 11/01/2016
co-authors: Melanie Walker



France: Refugees trying to reach the UK from The Jungle in Calais
© UNHCR/Joel van Houdt

Armed conflict and violence disrupt social support structures and exposes civilian populations to high levels of stress. The [2015 Global Burden of Disease](#) ^[1] study found a positive association between conflict and depression and anxiety disorders. While most of those exposed to emergencies suffer some form of psychological distress, accumulated evidence shows that 15-20% of crisis-affected populations develop mild-to-moderate mental disorders such as depression, anxiety, and post-traumatic stress disorders (PTSD). And, 3-4% develop severe mental disorders, such as psychosis or debilitating depression and anxiety, which affect their ability to function and survive. If not effectively addressed, the long-term mental health and psychosocial well-being of the exposed population may be affected.

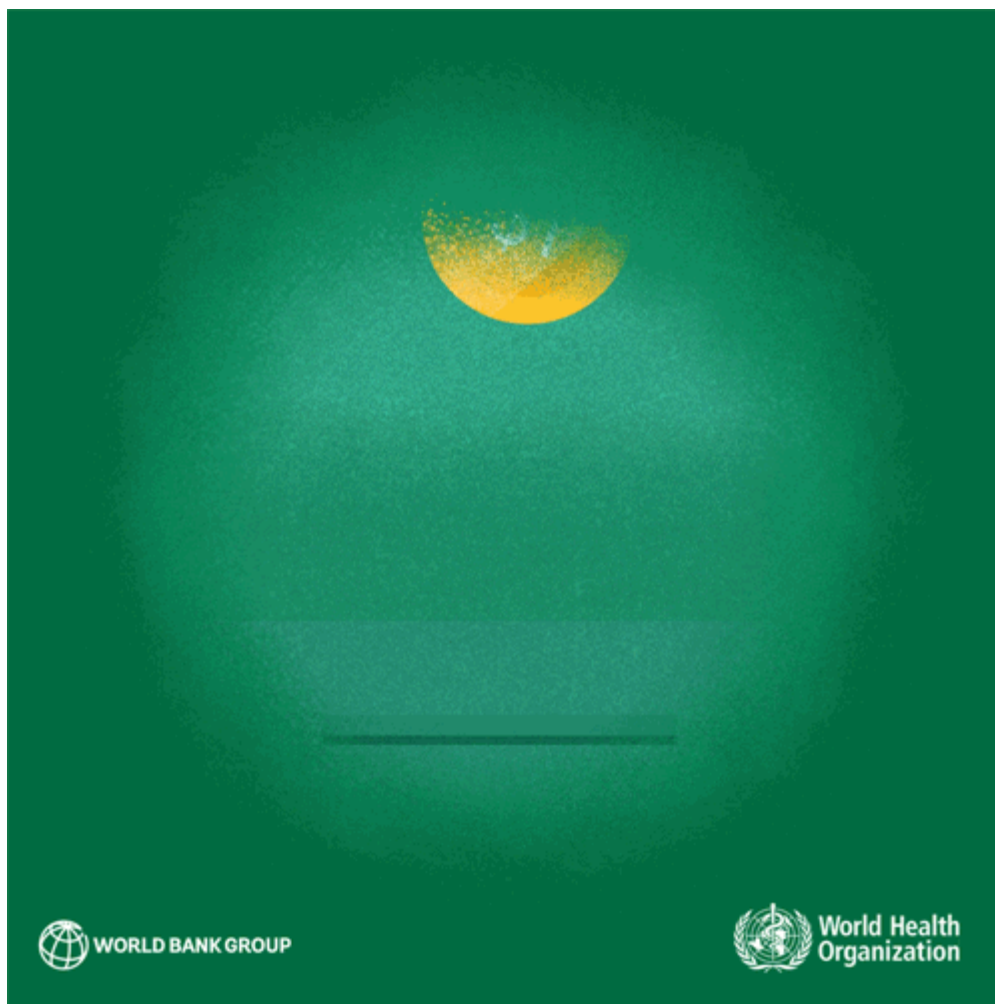
In conflict or post-conflict situations like those currently faced in the Middle East, in some African countries, among refugees flowing into European Union countries, or the 7 million internally displaced population after 52 years of conflict in Colombia, one of the priorities is to develop programs to protect and improve people's mental health and psychosocial well-being. In these situations, much-needed mental health care can be incorporated as part of humanitarian and development responses. Since affected populations are at an increased risk of mental disorders and psychological distress, inaction can severely overwhelm the local capacity to respond, particularly in settings where social networks and roles have been altered, and the health and social services infrastructure was already weak or rendered dysfunctional by crisis situations.

Is there a robust body of evidence to make the case for integrating mental health services in crisis response and addressing common skepticism at national and international levels? The simple answer is yes. Organizations such as the World Health Organization (WHO), the United Nations Refugee Agency (UNHCR), Partners in Health (PIH), International Medical Corps (IMC), Grand Challenges Canada, and the Mental Health Innovations Network have accumulated vast amounts of evidence about what to do in conflict and post-conflict settings. The 2016 Disease Control and Priorities report on Mental, Neurological, and Substance Use Disorders, which draws on the knowledge of institutions and experts from around the world, also provides a "gold standard" assessment and evidence on burden, interventions, policies and platforms, and economic evaluation.

The evidence is clear. Effective scaled-up responses to improve the mental health and psychosocial wellbeing of conflict-affected populations require careful adaptation to specific contexts of multi-layered systems of services and supports (e.g., provision of basic needs and essential services such as food, shelter, water, sanitation, and basic health care; action to strengthen community and family supports; emotional and practical support through individual, family or group interventions; and community-based primary care health systems). This allows a focus on affected individuals as a whole, addressing both their physical and mental health needs, while reducing the risk of stigma and discrimination among families and communities. This is important since mental disorders are highly co-morbid with other priority conditions (e.g., maternal and child health conditions, HIV/AIDS, and non-communicable diseases such as cancer and diabetes).

To inform the design of context-specific interventions in emergency settings, the mapping of the problem is of paramount importance, including assessment of mental health and psychosocial information about the affected population, covering both those with disorders induced by the crisis, and those with preexisting disorders. Such assessments can also clarify what is the current availability of mental health services in affected settings.

As illustrated by PIH experience in countries such as Haiti, Rwanda, Peru, and Liberia, many effective, evidence-based interventions are available and can be grouped into an essential package of interventions along a **mental health value chain at community and facility levels**, that includes **prevention** (e.g., community stigma reduction); **case finding** (e.g., psychological assessment, diagnosis); **treatment** (e.g., counselling, psychosocial interventions such as cognitive behavioral therapy, and treatment with essential medicines such as antidepressant and antipsychotic medications); **follow-up** (e.g., monitoring of symptoms); and **reintegration** (e.g., social and economic interventions).



Are these interventions cost-effective? A WHO-led study prepared for the WBG/WHO global mental health event at the 2016 WBG/IMF Spring Meetings showed that the estimated cost of treatment interventions at the community level for moderate to severe cases of depression, including basic psychosocial treatment for mild cases and either basic or more intensive psychosocial treatment plus antidepressant drug for moderate to severe cases, is quite low: the average annual cost during 15 years of scaled-up investment is \$.08 per person in low-income countries, \$0.34 in lower middle-income countries, \$1.12 in upper middle-income countries, and \$3.89 in high-income countries. Per person costs for treatment of anxiety disorders are nearly half that of depression. In terms of the economic returns on investment, benefit-to-cost ratios for scaled-up depression treatment across country income groupings were in the range of 2.3 to 2.6. For anxiety disorders, the ratios were slightly higher, with a range 2.7–3.0.

We have to be clear that the provision of mental health and psychosocial support services at the community level cannot be seen only as a vertical or free-standing intervention offered in a health facility. Rather, it needs to be part of broad integrated platforms—population, community and health care—that provide basic services and security, promote community and family support through participatory approaches, and strengthen coping mechanisms not only to improve people’s daily functioning and wellbeing, and protect the most vulnerable (e.g., women and children, adolescents, elderly, and those with severe mental illness) from further adversity, but also to empower the affected people to take charge of their lives as valuable members of society.

If this is done, as Toluwalola Kasali observed, we will be helping the affected people regain “the ability to dream, desire and work for a future, one very different from their present circumstances.”

Published on *Nasikiliza* (<https://blogs.worldbank.org/nasikiliza>)

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Mental health and intimate partner violence in Kenya



Submitted by Phiona Naserian Koyiet On Sat, 12/03/2016



Photo Credit: World Vision Kenya

Mental health has a crucial role in the prevention of sexual and gender-based violence. However, to date most research and practice has focused on the role of mental health post-violence, and intimate partner violence (IPV) prevention is relying on public health models that do not explicitly include mental health. Yet, key concepts, processes, and competencies in the mental health field appear essential to successful IPV primary prevention.

Women's subordinate status to men in many societies, coupled with a general acceptance of IPV as a means of resolving conflict, renders women disproportionately vulnerable to violence from all levels of society. Men's use of violence against women is a key determinant of the inequities and the inequalities of gender relations that both disempower and relegate women to extreme poverty.

Statistics indicate that Kenya has some of the highest rates of violence against women in the world. ^[1] **One in three** Kenyan females experience an episode of sexual violence ^[2] before age 18. The Kenya Demographic Health Survey ^[3] of 2014 showed that 45 percent of women aged 15-49 have experienced either physical or sexual violence. More than 41% of Kenyan women experience sexual and/or physical violence by intimate partners in their lifetime, while in a 12-month period, 31% of women are living with active violence in their homes. In over 90% of reported cases, men are the main perpetrators of violence; however men can also be victims of violence, with one in five Kenyan males having experienced an episode of sexual violence before age 18.

World Vision Kenya ^[4] received support from the Sexual Violence Research Initiative and World Bank Group Development Marketplace for Innovations to Prevent Gender-Based Violence ^[5] to launch a project aimed at reducing intimate partner violence in two peri-urban communities in Kenya. The project will target men with common mental health problems such as depression and anxiety, acknowledging the links between men with mental health problems, alcohol and substance use and high incidences of IPV.

An ethnographic study among the project's targeted communities confirmed that violence in the home, including IPV, is a major concern. Men reported that they may be inclined toward perpetration of violence given stressors such as unemployment, excessive alcohol and substance use, and family difficulties, as well as other psychosocial, cultural and gender issues. The qualitative data also verified a cyclic link between the impacts and causes of IPV; men under stress tend to consume more alcohol and are more likely to perpetrate IPV, while men who consume alcohol are more likely to be unemployed and thus experience greater familial problems that can contribute to IPV in the home. The study substantiated that a mental health intervention for men may yield benefits to support men to better manage stressors ^[6] and potentially reduce IPV in their homes.

The project will assess the feasibility, acceptability and effects of reducing violence using Group Problem Management Plus (GPM+), a cognitive behavioral treatment for men with common mental health problems, and explore the inclusion of community messages about IPV. The study will help determine if this approach warrants more rigorous research trials in the future. The project builds on Problem Management Plus (PM+) ^[6], an evidence-based intervention delivered by trained and supervised community health workers.

How will we test the intervention?

World Vision Kenya will conduct a small pilot study to verify tools and GPM+ strategies before conducting a definitive feasibility study. The feasibility study will include focus group discussions and interviews with clients, male and female community health volunteers, and clinical supervisors.

Delivery of community-based messages (in one of the two communities) that challenge local gender norms and understanding about violence against women, will ascertain if wider community engagement has additive impacts. Community surveys will compare incidences of IPV in the intervention community with the control community, where such messages will not be delivered.

For more information and to share your thoughts about this work, contact Phiona Naserian Koyiet at Phiona_Koyiet@wvi.org ^[7]

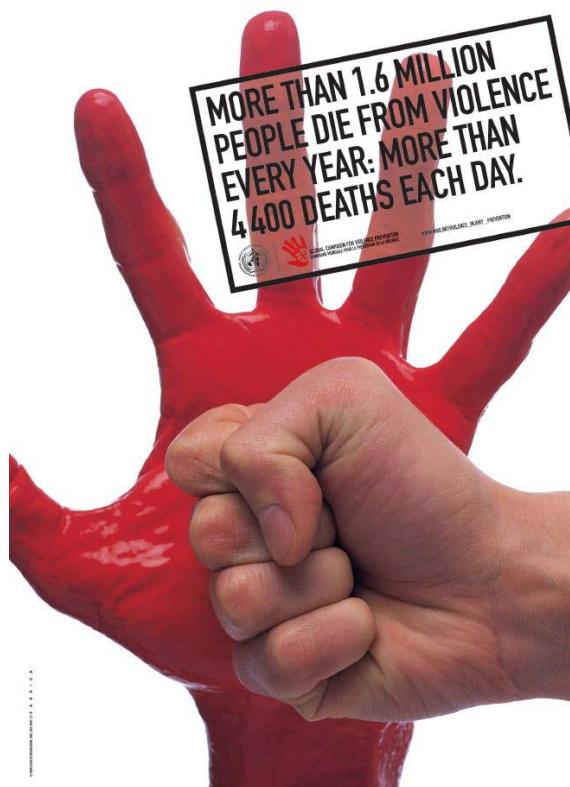
Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Is Violence a Public Health Problem?

Is Violence a Public Health Problem?



Submitted by Patricio V. Marquez On Wed, 04/08/2015



Reading Nobel Laureate Gabriel Garcia Marquez’s masterpiece “One Hundred Years of Solitude,” one is confronted with an unsettling reality: In the mythical town of Macondo, violence is an accepted mechanism used by successive generations to deal with individual and social conflicts. It also inflicts enduring pain on the town’s people long after disputes are settled with blood.

While “magic realism” is at the core of Garcia Marquez’s novel, let’s not forget that its depiction of violence and its after-effects was shaped by real historical events in Latin America--events that continue today to illustrate the inexorable reality of violence and its negative impact on families and communities everywhere.

Since violence in its many forms—interpersonal, self-directed and collective—often leads to physical and mental impairment, disability, and premature death, it should be seen as a major public health issue that requires sound epidemiological assessment of its causes, as well as multisectoral policies and strategies, including public health interventions. Let me make the case.

The relative importance of violence as a public health issue is clearly illustrated by the results of the 2013 Global Burden of Disease Study, which shows that interpersonal violence and self-harm are among the top 25 causes of

global years of life lost. And a recent report by the World Health Organization (WHO) estimated that about 500,000 deaths occurred worldwide in 2012 as a result of homicide alone.

Interpersonal violence, which is violence that occurs between family members, intimate partners, friends, acquaintances and strangers, and includes child maltreatment, youth violence, intimate partner violence, sexual violence, and elder abuse, is particularly endemic in Latin America and the Caribbean, where it is ranked among the top five causes of years of life lost in 15 countries of the region.

Indeed, WHO data indicate that low- and middle-income countries in the Americas have the highest estimated rate of homicide in the world (28.5 per 100,000 population), followed by the Africa region (10.9 per 100,000 population).

By contrast, the rate in high-income countries has declined over the 2000-2012 period to a low of 3.8 per 100,000 population.

In some of countries in Latin America, the problem is severe: young adults in El Salvador have the highest probability of death from interpersonal violence in the world, and people in Central America, more than any other region, are most at risk of being killed violently.

Key risk factors for interpersonal violence are strongly associated with weak governance, poor rule of law, cultural, social and gender norms, limited educational and employment opportunities, and social inequality. Also, ease of access to weapons and alcohol abuse and drug use contribute to multiple types of violence.

In turn, non-fatal physical, sexual and psychological abuse contribute to lifelong ill health and premature death due to diseases such as heart disease, stroke, cancer and HIV/AIDS that result from unhealthy behaviors (smoking, alcohol and drug misuse, and unsafe sex) that victims of violence often adopt to cope.

In spite of the severity of the problem, the WHO report indicates that lack or limited data on homicides from civil or vital registration sources is common in a vast array of surveyed countries, hindering the design, implementation and monitoring of prevention efforts.

Besides calling for strengthened data collection to better understand the true extent of the problem, the report also advocates for enhanced governmental action to address key risk factors for violence through cross-sectoral policies and institutional measures. These could include improving the enforcement of existing laws to deter crime and violence and making medical, social, and legal services available to identify, refer, protect and support victims of violence.

Good practices serve to illustrate that interpersonal violence and negative social consequences can be prevented and mitigated if the roots of the problem are known.

One such practice can be found in Cali, Colombia. By investigating and collecting data and information, the Cali municipal government, with the support of a university center, the police and the judicial system, determined that most homicides occurred on weekends, holidays, and Friday nights coinciding with payday; that about 30% of the victims were intoxicated; and that 80% of all the victims were killed by firearms.

Guided by this knowledge, the city established *Desepaz*, a violence prevention program, to address the key risk factors for homicide—alcohol and firearms—by adopting measures such as limiting the hours that alcohol could be sold on weekdays and weekends, and gun bans in the city.

Building upon the Cali experience, the municipal government of Bogota, Colombia's capital, adopted similar measures which contributed to reducing the homicide rate from 80 per 100,000 population in 1993 to 16 in 2012. Other countries in Latin America and the Caribbean are also starting now to standardize and share data on crime and violence under an Inter-American Development Bank-supported initiative to tackle these phenomena.

While violence prevention is a complex challenge, given its broad social determinants, Colombia's experience shows that effective solutions are possible.

Political commitment and coordinated multisectoral action should be informed by systematic collection and utilization of data and information. If this is not done, countries are destined to live perhaps not "100 years in solitude" but to be fragile and vulnerable. Their development prospects may well continue to be undermined by high human capital and economic losses, as well as by the erosion of social capital due to fear among the population that perhaps the next victim of violence will be a loved one.

Follow the World Bank health team on Twitter: [@WBG_Health](https://twitter.com/WBG_Health) ^[1]

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > The case for physical and mental wellness programs in the workplace

The case for physical and mental wellness programs in the workplace



Submitted by Patricio V. Marquez On Thu, 09/28/2017



The launching of the iPhones 8 and X and the advent of genomic-based precision medicine for disease treatment and prevention, are new reminders that technological innovation is fueling momentous change in our daily lives. Indeed, as Professor Klaus Schwab, the chairman of the World Economic Forum describes, the physical, digital and biological trends underpinning what he calls '[the fourth industrial revolution](#)'^[1], are unleashing changes “unlike anything humankind has experienced before.”

In the face of rapid and disruptive economic and social change, what can be done to build social resilience, keeping people at the center of the development process?

One way to address this question is to heed the advice of Prof. Schwab and promote as a shared value proposition, the notion that organizations and businesses have in their role as employers a great responsibility to nurture employee

resilience. A healthy workforce is after all vital to a country's competitiveness, productivity, and wellbeing. The latter is easily grasped when one considers that poor health and well-being costs the UK economy up to US\$75 billion a year in lost productivity due to a combination of absenteeism, employees not being at work, and presentism.

But let's be clear. The reduction of health risks for physical conditions needs to be complemented with action to prevent and address mental ill health, an often-ignored reality in the workplace. Mental ill health is a condition of the brain that should not be treated differently than other chronic health conditions, such as heart disease or cancer. Nor, in fact, are they truly separable: If untreated, mental illnesses can negatively affect management of such co-occurring diseases as tuberculosis and HIV, diabetes, hypertension, cardiovascular disease, and cancer.

Workplace wellness programs: good for employers and employees

As most of the working population spend a majority of their time at work, the workplace provides a unique but often ignored opportunity to raise awareness about physical and mental health risks and to offer programs under benefit plans that guide and incentivize individuals to develop healthier behaviors. In turn, these programs can have a positive multiplier effect, as employees integrate health and well-being into the daily routines of families and communities. Workplace wellness programs include in general screening activities that use self-administered questionnaires on health-related behaviors (e.g., physical activity, use of seat belts when driving), risk factors (e.g., tobacco use), and psychological conditions (e.g., stress, anxiety and depression), as well as clinical screenings to collect biometric data—e.g., height, weight, blood pressure, and blood glucose. The data from these assessments help identify health risks and interventions to promote lifestyle changes. As part the programs, guidance and incentives are offered to employees to participate in *primary prevention activities* to modify risk factors for chronic disease (lifestyle management) and *secondary prevention activities* for dealing with manifest chronic conditions (disease management). Other common health promotion activities include on-site flu vaccination and counseling support.

The business case for supporting these programs is sound: Employers expect that wellness programs will improve employee health and well-being and lower medical costs, especially with the growing burden of chronic conditions such as cardiovascular disease, cancer, diabetes, and mental ill-health. Also, these programs can help to attract and retain talented workers, increase productivity, and reduce absenteeism.

There is growing evidence on the significant impact of these programs. In the United States alone, wellness programs are now a US\$6 billion industry, with more than half of firms with at least 50 employees offering these programs. Results of a 2013 [national survey](#) ^[2] conducted by the Rand Corporation showed that meaningful improvement among program participants in exercise frequency, smoking cessation, and weight control over a four-year period. The study also found that participation in a wellness program over five years is associated with a trend toward lower health care costs. The return-on-investment is noteworthy when comparing the ratio of reductions in health care costs (e.g., keeping people healthy and out of hospital) to program costs: wellness programs generated a return of \$1.50 for every \$1 invested and a return of \$3.80 for every \$1 spent on disease management.

A [study](#) ^[3] done by the World Economic Forum, covering 25 firms with 2 million employees in 125 countries around the world, also shows that firms that champion workplace wellness are reaping significant benefits measured in terms of increased productivity, reduced cost of employee healthcare, and increased employee engagement that lead to reduced turnover.

Where wellness programs often fall short

While physical health-related metrics are promising, tackling mental illness in the workplace is lagging. This is a major challenge that needs to be addressed head on given the enormous burden of mental ill health at home and the workplace, aggravated by widespread stigma and discrimination of affected people. In the UK, for example, about 40 percent of the workforce's sickness absence, was due to stress, depression, or anxiety – an average of 23 days per affected person- in 2013-2014.

Helping address mental ill health risks in the workplace could contribute to generate significant benefits for workers and firms alike. A [study](#)^[4] prepared for the 2016 World Bank Group-World Health Organization Global Health Conference estimated that the returns on this investment in a country can be substantial as measured by a favorable benefit-to-cost ratio, ranging between 2.3-3.0 to 1 when economic benefits only are considered and 3.3-5.7 to 1 when social returns are also included.

Moving forward

Properly implemented, wellness programs in the workplace are a “good buy” for any organization and business, with significant returns in terms of health and economic gains. These programs can also contribute to accelerate the progressive realization of universal health coverage by engaging and leveraging resources and know-how from organizations and businesses for the benefit of workers and families alike.

Nurturing the development of healthy work environments that promote the physical and mental well-being of employees is not only the right thing to do, but it’s a smart economic decision to improve productivity and competitiveness of firms, both crucial to help national economies combat poverty and achieve sustainable development.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Healthier Workplaces = Healthy Profits



Submitted by Patricio V. Marquez On Tue, 01/22/2013



The debate in the United States on how to change a health system that is geared to treat illnesses to one that focuses on preventing people from getting sick stirred my curiosity on how companies can improve employee health. After all, employees spend most of their waking hours at the workplace.

There is robust body of evidence showing that investment in workplace wellness programs is not only good for employees but also for the bottom line of companies. These programs, which are employer-organized and sponsored, help employees, and in some cases, their families, adopt and sustain behaviors that reduce health risks associated with chronic diseases and injuries. Both employees and employers value these programs because they help reduce health risks, absenteeism and employee turnover.

We know from a [recent study](#) [1] that the entry point for participation in these programs is employee health risk assessments, coupled with clinical screening for risk factors (e.g., blood pressure, cholesterol, and body mass index) that provide the baseline for subsequent interventions. Other methods include self-help education materials, individual counseling with health care professionals, and on-site group activities led by trained personnel. Besides obesity and smoking cessation, programs commonly focus on stress management, nutrition, alcohol abuse, and blood pressure, and on preventive care such as the administration of the flu vaccine. Companies have begun giving incentives to motivate healthy behavior, such as bonuses for completing health risk assessments, reimbursements for the cost of fitness center memberships, or lower health insurance premiums if employees adopt healthier behaviors (e.g., quit smoking).

As we continue to make strides in global health, we need to see the workplace as another promising “entry point” to tackle not only unhealthy behavior among individuals but also to reduce community health risks (e.g., through the adoption of programs to better train truck drivers and conduct regular vehicle inspections to prevent road traffic deaths).

So what are the essential pillars of these programs? According to [an assessment](#) [2] in the *Harvard Business Review*, they are:

Engaged leadership: *Johnson & Johnson* helps employees living with HIV/AIDS access antiretroviral drugs. Additionally, all of its facilities are smoke-free.

Strategic alignment with the company's identity and aspirations: To promote a culture of health in a company where 60%-70% of jobs are safety-sensitive, *Chevron* has made fitness for duty a central concern on oil platforms and rigs, in refineries, and during the transport of fuel. Its wellness program includes a comprehensive cardiovascular health component, walking activities, fitness centers, stress-injury prevention, and work/life services.

Design that is broad in scope and high in relevance and quality: To be relevant to the needs of their employees, companies have adopted programs that are not just about physical fitness but also focus on mental health issues such as depression and stress, which are major sources of lost productivity.

Broad accessibility: SAS, a software firm, makes low- or no-cost services a priority. This is complemented with convenient arrangements that ensure high employee participation, for example, recreation facilities that are open before and after work and on weekends.

Internal and external partnerships: Companies offer services, such as biometric health screenings, at the worksite. These, in turn, are used to devise "individualized" programs with a local sport club and medical practice for at-risk employees.

Effective communications: To help overcome employee apathy or sensitivity about personal health issues, some companies are sharing information about wellness in regular corporate e-mails, health-related messages on intranet portals, and wellness "clues" in the workplace, such as the availability of bicycle racks in parking garages with showers nearby to make cycling to work appealing.

What are the returns on this investment? In the case of *Johnson & Johnson*, since 1995 the percentage of employees who smoked dropped by more than two-thirds, and the number who had high blood pressure or were physically inactive declined by more than half. The companies reaped financial rewards as well: Thanks to wellness programs in the workplace, medical costs for U.S. firms fell by about US\$3.27 and illness-related absenteeism costs dropped by about US\$2.73 for every dollar spent on such programs.

Governments can play an important role in helping implement and expand employer wellness programs, not only to improve the health of the population, but also to control health care spending. The 2009 Affordable Care Act, adopted by the U.S. Government to expand health insurance coverage, is a [good example](#) [3] as it expands employers' ability to reward employees who meet health status goals by participating in wellness programs and to require employees who don't meet these goals to pay more for their employer-sponsored health coverage.

Follow the World Bank Health team on Twitter: [@worldbankhealth](#) [4].

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Is Unemployment Bad for Your Health?



Submitted by Patricio V. Marquez On Thu, 01/22/2015



The media have been reporting these days that the U.S. economy continues to grow, and more people are being hired each month, bringing the unemployment rate down to 5.6%--a level not seen since the late 1990s. Unfortunately, in some parts of the world, the negative impact of the 2008 Great Recession continues to be felt. Among some European Union countries, the share of the unemployed remains at unprecedented high levels, particularly among young adults. In Spain and Greece, for example, the unemployment rate is about 25%.

As discussed in a [recent paper](#) ^[1] by researchers from the Urban Institute, being out of work for six months or more is associated with lower well-being among the unemployed, their families, and their communities. While tax and social transfer programs can help mitigate the consequences of long-term unemployment, a decline in family income due to a worker's lack of earnings directly reduces the quantity and quality of goods and services the worker's family can purchase, and exacerbates stress as well. The erosion in the tax base used to fund essential public services, such as health care, can negatively affect individuals and families by constraining access to these services when needed.

So, the question for those of us working in the health sector is how unemployment and its duration, as well as its consequences, affects individuals' health behaviors and health outcomes, and what can be done to ameliorate them?

The authors of a [longitudinal study](#) ^[2] just published by the National Bureau of Economic Research (NBER), which tracked the same people over two recessions in the United States, including the Great Recession of 2008, caution against broad generalizations about the consequence of job loss on individual health behaviors. That is because, they argue, behaviors vary differently in the face of resource constraints, stress level due to job loss, and expectations regarding prolonged duration of job loss.

In terms of the effect of unemployment on physical activity (energy expenditure), food consumption (energy intake), and the effect on body weight (as measured by body mass index or BMI), the study found that both energy intake and expenditure decline after a job loss, leaving BMI unchanged or slightly higher (mostly among previously obese individuals). The study also found that among females, job loss is associated with an increase in the probability of being a current smoker, consistent with a decline in smoking cessation or a relapse into smoking among former smokers due to stress. Among males, the study found no significant effect on smoking, although, similar to females, there is a reduction in cigarettes consumed among heavy smokers.

Since physical activity can be health-promoting, the paper concludes that even though unemployment is only weakly associated with weight gain, lower total physical activity which reflects high job losses in manual labor (e.g., housing construction) and spending more time on sedentary activities (e.g., watching TV, surfing the internet), may have adverse effects on health. Also, unemployed people are more likely to delay routine health care visits or taking medication because of income constraints or because they have lost their health insurance.

In terms of change in the association between macroeconomic conditions and overall mortality, another [NBER study](#) ^[3] found effects for specific causes of death, rather than changes in the composition of total mortality across causes. For example, the lack of a significant effect of unemployment on changes in healthy behaviors is consistent with evidence that cardiovascular disease deaths have not changed dramatically over time, while road traffic fatalities tend to decrease during economic downturns because reduced income due to unemployment is associated with a decrease in miles driven in a car.

A negative correlation is found over time for cancer fatalities and some external sources of death (particularly those due to accidental poisoning). The study concluded that the changing effect of macroeconomic conditions on cancer deaths may partially reflect the availability of financial resources or health insurance coverage, which can be used to obtain high-cost, specialized treatments.

An increase in observed deaths as a result of accidental poisoning may occur due to increased stress or depression related to job loss during economic downturns. This, in turn, is associated with the use of prescribed or illicitly obtained medications that carry risks of fatal overdoses. Additional evidence presented in a [BMJ article](#) ^[4] shows that, after the 2008 economic crisis, rates of suicide increased in a group of European and American countries studied, particularly among men and in countries with higher levels of job loss.

Given the cyclical nature of economic activity, perhaps those of us in the health sector working as part of cross-sectoral teams need to place particular attention on understanding more clearly the underlying mechanisms through which losing a job impacts health behaviors and conditions, both during and after economic downturns and in situations of long-term unemployment. This type of knowledge is essential for developing evidence-based policies and programs to ameliorate the consequences of job loss, particularly

among those who are most vulnerable to economic and health shocks, and ensure that they are protected and supported throughout and after the crisis.

Follow the World Bank health team on Twitter: [@WBG_Health](#) ^[5].

4.

**Achieving Mental Health
Parity is Critical for the
Progressive Realization
of Universal Health
Coverage (UHC)**

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Time to put “health” into universal health coverage



Submitted by Patricio V. Marquez On Thu, 01/14/2016



photo by: Patricio Marquez

While on a walk with my younger son over the holidays, we got into a good discussion about the future of health care. After taking a class on health economics this past semester, he wanted to share his perspective about the need to “do something” to deal with the high cost of medical services that are pricing people out of health care in many countries.

Contrary to arguments used to justify the need for expanding access to services without putting patients at risk of impoverishment when they have to pay out-of-pocket for services rendered, even when they have health insurance, I was pleasantly surprised by his prescription. He said: we need to focus on “keeping people well” rather than only “treating the sick.”

As a public health professional, I could not agree more.

In 2015, we saw significant movement toward the goal of universal health coverage, culminating in a high-level meeting last month in Tokyo at which global leaders [highlighted](#) ^[1] the need to accelerate progress toward affordability of care and access to basic services.

To achieve these objectives, and to ensure the financial sustainability of health systems, which can be severely undermined by the uncontrolled rise of health care costs, it is important that the push toward UHC include efforts to change lifestyle choices that contribute to chronic disease.

To be clear: this is not only a predicament affecting developed countries. Given the growing relative importance of non-communicable diseases and injuries across the world, developing countries are also starting to face this unavoidable dilemma but without the resource base, health systems or coverage levels of developed countries.

Are disease and injury prevention then the “cure” for this global challenge? In large measure this may be the case. However, this course of action requires a fundamental rethinking of how to best keep people healthy and out of the hospital.

For starters, there has to be a widespread realization among policymakers, employers, health insurers, service providers, and the population at large, that the lion’s share of health care expenditures goes for treating diseases and injuries that could be “prevented”. This, however, would require priority attention for supporting population-wide efforts to tackle social and behavioral determinants of ill health and premature mortality, such as policy measures to curb tobacco use, second hand smoke, alcohol and substance abuse, obesity and Type-2 diabetes, road traffic injuries, and in some countries, gun violence.

Besides regular collection and dissemination of data on the nature and characteristics of health risks and associated conditions needed to guide policy formulation and implementation, including funding allocations, active involvement of different stakeholders is required to advance this public health agenda.

Taxation and regulatory measures, as well as “institutional nudges” such as offering healthier lunch options in the staff cafeteria, can help influence behavior change and reduce the social acceptability of health risks. High taxes on tobacco that make cigarettes unaffordable, for example, coupled with smoke-free public spaces and bans on advertising, have been shown to reduce consumption and prevent addiction among youth. Community-based nutrition and physical activity programs have also proved to be effective in helping control obesity and the onset of diabetes. Strict enforcement of laws against drunk driving has contributed to significant reduction of road fatalities across the world.

Insurance arrangements and health care organization and payment innovations are increasingly used in different countries to advance this public health agenda as well. For example, insurance companies, by charging lower premiums for those who quit smoking, lose weight, and pass screening tests for artery-clogging cholesterol, high blood pressure, and high sugar levels, provide an incentive for individuals and families to assume responsibility for their health.

Health care reforms that promote care coordination among hospitals, physicians, nurses, therapists and home care providers in accordance with evidence-based care protocols and that reimburse services using annual or capitated fees for members of an assigned population, are used to promote collaborative structures centered on ambulatory, community-based, primary care services. These arrangements have the potential to reduce costly emergency room visits and inpatient services through early detection and treatment of chronic diseases and by keeping people healthy and out of the hospital.

There are also generic drugs to treat most of these conditions as a secondary prevention measure. Statins, for example, are prescribed to reduce cholesterol and lower the risk of heart attacks and strokes. But measures to keep people on medication adherence need to be adopted to reduce the risk of disease progression or the development of multi-drug resistant conditions, including facilitating access to low-cost generic drugs, since the high cost of drugs that control chronic diseases may be a disincentive to use them.

The use of smartphones and specialized apps can help keep people healthy, via text message reminders about medication schedules; keep track of lab results and vital signs; and monitor progress in achieving personal health goals.

Many employers are offering on-site clinics as part of workplace health or wellness programs to help workers access health promotion counseling to encourage exercise and diet regimens, and to provide secondary prevention services such as flu vaccination, screening for high blood pressure and blood sugar levels, and psychosocial support for anxiety and depressive disorders and alcohol and substance abuse. In the United States, for example, it is estimated that one-third of firms that have 5,000 or more employees now have such clinics.

As we start the New Year, it is time to make the case for giving more attention to health promotion and disease prevention as part of scaling up of universal health coverage. Let's make our goal healthy people and not simply more health services. The realization of this goal, however, has to be a shared social responsibility!

Follow the World Bank health team on Twitter: [@WBG_Health](https://twitter.com/WBG_Health) ^[2]

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Mental Health Parity in the Global Health and Development Agenda



Submitted by Patricio V. Marquez On Tue, 04/05/2016
co-authors: Shekhar Saxena



Why are mental disorders and substance use disorders treated so much differently than other health conditions? This is just one of the many questions that the World Bank Group, World Health Organization and other international partners will pose at their upcoming event -- *Out of the Shadows: Making Mental Health a Global Development Priority* ^[1] -- on April 13th -14th , as part of the 2016 WBG/IMF Spring Meetings.

If mental health disorders are conditions of the brain, why do we treat these conditions so differently than heart conditions or cancer? And in doing so, do we realize that this approach ignores all of the evidence that shows us that mental illness is a major disability burden worldwide? If untreated, mental disorders can negatively affect management of common co-occurring diseases, such as tuberculosis and HIV, diabetes, hypertension, cardiovascular disease, and cancer.

For all of these reasons and many more, the WBG-WHO are aiming to put the mental health agenda where it belongs -- at the center of global health and development priorities and remove all disparities.

In his sobering and deeply touching memoir, *A Common Struggle*, former U.S. Congressman Patrick J. Kennedy, shares his personal struggle with mental disorders and substance abuse and unpacks some of the issues surrounding mental health.

In the United States, as well as in countries such as Chile, Colombia and Ghana, where they are trying to push for equality for mental illnesses and addiction treatment, a common barrier to overcome is preexisting conditions clauses that deny health insurance coverage. And even if this hurdle is overcome, explained Congressman Kennedy, who will deliver a keynote at the event, the next big issue is to determine what is covered, funded, and enforced at the provider level. And this leads to a whole host of additional questions, such as:

- Would coverage be offered for common mental illnesses such as depression and anxiety disorders, or just for severe mental illnesses such as schizophrenia, bipolar disorder, and disabling clinical depression?
- Would addictions be covered?
- How to select the menu of evidence-based treatments to be offered by service providers at different levels of care, as is commonly done for other health conditions at the community level and on ambulatory clinics, local hospitals or specialized treatment centers?
- We know that services for mental disorders depend heavily on adequate number of trained health personnel; how do we bridge the gap in their availability?
- How about drugs, are they going to be brand name or equally effective generics? Who decides and on what basis?
- Would there be a mandate for all public and private insurance plans to cover mental health?
- And how are these services going to be funded and reimbursed, particularly not to perpetuate medical discrimination in the subtle way of high deductibles, copayments, and lifetime limitations in coverage under health insurance arrangements?
- What strategies can be used to integrate mental health care as part of services delivery platforms that focus on the patient as a whole rather than an aggregation of separate diseases?
- And even if all these policy and service delivery changes are adopted, would affected persons who need mental healthcare and their families defy the stigma of being seen as “mental ill” and get services and adhere to prescribed medication and psychotherapies?
- What can be done to create facilitating workplace environments that help affected people overcome fear of losing a job or health insurance coverage if one were to disclose a mental health affliction and seek mental healthcare when needed?

At the same time that we pose these questions that have both political and financial implications, we also need to explore other “entry points” across sectors to bring mental health out of a centuries-old shadow—from school-based interventions, wellness and health in the workplace programs, initiatives to address the physical and mental health needs of displaced populations, refugees, and persons living in post-conflict, post-natural disasters, epidemics and post-epidemic (e.g., Ebola in West Africa) situations. To that end, we need to build upon social protection and employment initiatives that facilitate the reintegration of affected persons back into their communities as valuable members of society. Hence, by accepting that mental health is a development challenge, we need to pursue different cross-cutting and multidisciplinary approaches, and funding streams.

We already have the evidence-based medical treatments and support therapies that can help alleviate the silent suffering for so many. Political will and commitment to sustainable funding, improved and scaled up service provision as a right of the population is required. And besides the human toll, let’s not forget that the social cost of inaction is staggeringly high as measured in terms of broken families, less cohesive and inclusive communities, labor supply losses, high rates of unemployment among mentally-ill persons, disability costs, absenteeism and reduced productivity at work from unattended depression and anxiety disorders.

Let’s remain optimistic that recent attention and interest on this issue will lead to increased commitments to implementing a global, multisectoral effort to scale up mental health services in primary care and community settings.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Advancing global mental health action: lessons from Canada

Advancing global mental health action: lessons from Canada



Submitted by Patricio V. Marquez On Mon, 01/30/2017

co-authors: Shekhar Saxena, Melanie Walker

Also available in: [Español](#) ^[1], [Français](#) ^[2]



A portrait of Miliett Kangar at JFK Medical Center and E.S. Grant Mental Health Hospital in Monrovia, Liberia on March 07, 2016. (Miliett did not want to show her face in the picture)

Photo © Dominic Chavez/World Bank

In 2016, a lot of effort was placed on shining the light on mental health as a neglected issue in the global health and development agendas. The flagship event organized by the World Bank Group (WBG) and the World Health Organization (WHO) during the Spring Meetings of the WBG/IMF held in Washington D.C. was an important step to galvanize attention and commitment to change this situation.

There are countries, such as Canada, that show that well-designed frameworks, built upon broad consultations involving local, regional, and national groups, agencies, governments, and vulnerable population groups such as

Indigenous peoples and people with lived experience, and that enjoy the highest level of political commitment, can serve as good roadmaps for advancing the mental health agenda over the medium term.

The “Changing Directions, Changing Lives: The Mental Health Strategy for Canada” [3], along with the “Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)” [4] adopted to accelerate uptake and implementation of the strategy, offer some lessons for designing and implementing comprehensive national mental health strategies.

A key aspect of the Canadian mental health strategy is its humanistic orientation. It positions people living with mental health problems and illnesses and their families as the drivers of change in mental health. It also recognizes that success depends on the commitment of governments to set policies and fund services, as well as of other actors to regulate, accredit, monitor, and deliver services.

The framework for action is structured around **four pillars** that are geared to improve the mental health and well-being of people in Canada and the services they need:

- **Leadership and funding:** the mobilization of commitment and support from the highest political level is critical to better resource the mental health response and increase the capacity to deliver quality, evidence-based, and integrated services and better meet the needs of diverse population groups. While funding is important, it is emphasized that leaders need to focus on achieving parity between physical and mental health care, better integrating mental health and physical health, and fostering collaboration across the health, social, education, and justice sectors.
- **Promotion and prevention:** given the multisectoral nature of mental health problems and illnesses, upstream efforts are needed, placing more emphasis on holistic prevention strategies, promotion of mental wellness, increased awareness and education about positive mental health across the lifespan, and a more refined focus on the social determinants of health in a culturally competent and safe manner. Promotion and prevention must be complemented with efforts to uphold human rights, social inclusion, and eliminate stigma and discrimination.
- **Access and services:** making timely access to evidence-based, integrated, person-centered, holistic, high-quality mental health services across the continuum of care should be a priority. People with lived experience and their caregivers must be engaged at all service points and in the policy development process to truly improve the availability and quality of mental health services.
- **Data and research:** aside from developing benchmarks and ongoing evaluation of system performance, as well as the translation of evidence-based mental health knowledge into policy and practice, this pillar includes support for comprehensive, innovative, interdisciplinary research and evaluation on mental health problems and illnesses and mental health programs and treatments; facilitating the involvement of people living with mental illnesses in research; improving data collection systems and population-level monitoring to collect comprehensive information on mental health, wellness, illness, service access, and wait times and ensure that publicly-funded data is available to researchers and policy makers.

These pillars are in line with WHO’s Mental Health Action Plan 2013-2020, adopted by the World Health Assembly, consisting of all ministers of health, including of Canada.

Canada has also established itself as a leader on global mental health. Many Canadian agencies have been collaborating with international and national partners. For example, since 2012, Grand Challenges Canada (GCC) has invested more than 35 million Canadian dollars to fund over 70 innovative mental health projects in more than 28 low-and middle-income countries. These innovations have led to tens of thousands people receiving mental health care; GCC funded grants have the potential to improve thousands of additional by 2030. GCC has also supported the establishment of Mental Health Innovation Network, which shares information and knowledge for decision making to innovators, researchers, civil society and policy makers.

By defining a broad, multi-stakeholder, social compact to support mental health promotion and mental illness prevention and treatment, Canada's mental health strategy and the framework for action show the importance of an alternative "distributive social ethics" or "moral values" in developing public policies. That is, the well-articulated, socially inclusive goals and participatory mechanisms of the strategy illustrate that broad social goals are the basic parameters that ultimately guide and shape policy and institutional decisions concerning the most appropriate and contextually relevant organizational forms, financing arrangements, and service delivery mechanisms. The strategy also clearly distinguishes the intermediate goals (improved access, quality, efficiency, and fairness) from the ultimate goals of integrated mental health and social systems (improved social and mental and physical health conditions, financial protection, and user satisfaction with the services received), avoiding the risk of confusing the means and ends of policy action.

While recognizing that heterogeneous social, economic, and cultural country contexts preclude the mechanical adoption of other countries' experiences, the transnational sharing of knowledge and adaptation of relevant aspects of those international experiences to specific country realities is one of the benefits of living in an interconnected, globalized world. If inclusive mental health policy, programs, and services are going to thrive across the world to improve health outcomes for people with mental health problems and illnesses and their families, we will do well in recognizing that more than technical processes, their realization will depend, as Canada's experience shows, on social and political decisions as to what kind of society a country wants to have. Canada's contributions at the international level, also set an example for other countries to contribute to global mental health.

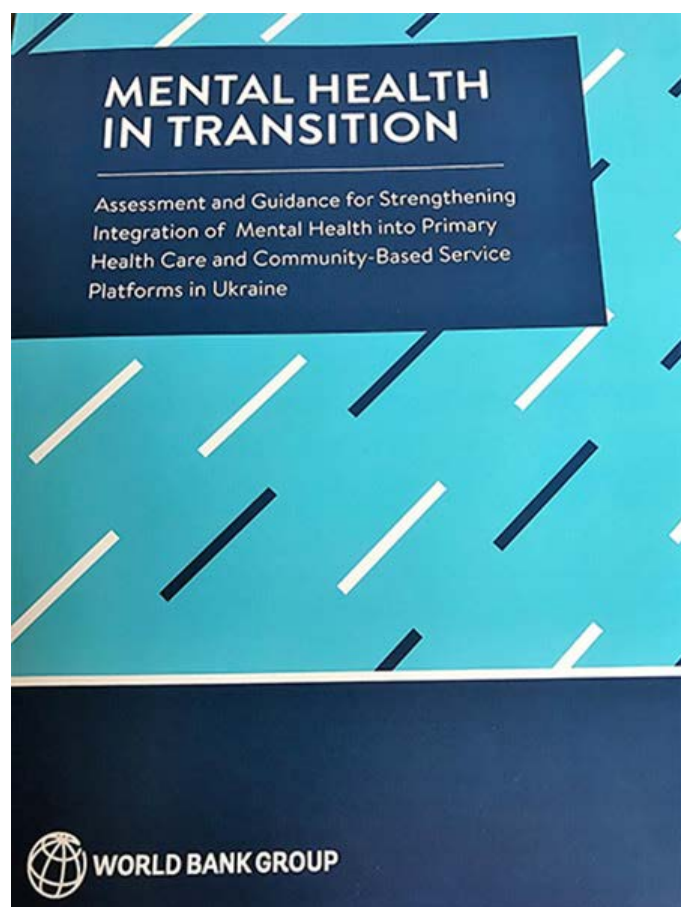
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Mental Health Parity is Critical for Achieving Universal Health Coverage in Ukraine



Submitted by Patricio V. Marquez On Wed, 12/20/2017
co-authors: Feng Zhao



A new report on mental health in Ukraine ^[1] offers a sobering picture of the often-ignored disease burden of mental disorders, which undermine human capital development and total wealth accumulation in a country. The World Bank Group estimates show that unaccounted “intangible capital” such as human capital, constitutes the largest share of wealth in virtually all countries, more than produced capital and natural resources.

The report is based on a comprehensive mental health assessment carried out in three regions (Lviv, Poltava, Zaporizhia). Evidence suggests that one-third of the Ukrainian population experiences at least one mental disorder in their lifetime, which is significantly higher than the global average. Alcohol use disorder (AUD) is more common among men, while anxiety and depression are more common among women.

Poor mental health is also tightly interconnected with poverty, unemployment, high out-of-pocket payments for medical care, and feelings of insecurity, compounded by the effects of the ongoing military conflict in the Eastern part of the country. Internally displaced populations (IDPs), older persons, and those living in conflict areas are especially vulnerable.

Yet, most people (up to 75%) with common mental disorders and AUDs have limited access to adequate mental health services in Ukraine. Stigma, prejudice, and fear of public recognition as being diagnosed with mental illness may result in job loss, and ruined social standing, further compound this problem.

The Way Forward

The report calls for integrating mental health as part of the ongoing health system reform program in Ukraine, seeking to create acceptance that mental disorders should not be treated differently than other chronic health conditions, such as cerebrovascular diseases or cancer. Nor, in fact, are they separable: if untreated, mental disorders can negatively affect management of such co-occurring diseases as tuberculosis, HIV, diabetes, hypertension, cardiovascular disease, and cancer.

This would require that reform efforts be prioritized to focus on strengthening coordination and leadership for mental health involving different actors at central and regional levels, civil society, private enterprise, and international organizations, and build on accumulated evidence to expand ongoing programs in selected regions.

The burden of mental illness in Ukraine is exacerbated by the lack of access to diagnose, misdiagnosis, and inappropriate treatment of ill mental health. Improving the delivery of psychosocial support and treatment would require the strengthening of referral pathways among different formal and informal service providers in the health and social systems, to foster communication, information sharing, education and training, and multidisciplinary teamwork. Mental health services must be decentralized from hospital-based care toward outpatient care and community-based services, including integration with primary health care. At the same time, these efforts would need to scrupulously protect patient confidentiality, given widespread stigma and discrimination.

Financing for mental health services must also be strengthened, as only 2.5% of the total health sector budget is dedicated to mental health care, and the majority (89%) of this funding goes toward psychiatric hospitals. One innovative way to do so is by raising the excise taxes on cigarettes and alcoholic beverages, which can expand the fiscal space to fund these programs while reducing health risks associated with tobacco- and alcohol-related diseases.

Although there has been a strong focus on trauma and post traumatic disorders (PTSD) in the context of the military conflict in eastern Ukraine, it is important to consider the much higher burden of depression and AUDs at the national level. While it is important to tailor mental health services to different groups (e.g., older persons, veterans), it is also crucial that services be accessible to all segments of the population. This would require a dedicated effort to build the capacity of human resources by education, certification programs, primary care provider outreach and education, strengthening the role of social workers, other community providers, including religious leaders.

As most of the working population spends a large proportion of their time at work, the findings of the report are also relevant for structuring wellness programs in the workplace, to raise awareness about physical and mental health risks and to offer programs under benefit plans that guide and incentivize individuals to develop healthier behaviors. In turn, these programs can have a positive multiplier effect, as employees integrate health and well-being into their daily routines. Lastly, the report stresses the importance of raising awareness of and providing information to the public about mental health problems and service providers, supporting the development of consumer-led mental health advocacy groups, and strengthening the engagement of persons recovering from mental illness and their family members.

The social costs of mental illness are terrible high in any society. Recent research shows that mental illness is a better predictor of misery than poverty is, while the costs of effective treatments are surprisingly low. If effective action is taken in Ukraine to address the unmet mental health needs of the population, significant positive social and economic returns will be generated. The report estimates that over 4.7 million years of healthy lives can be restored by the year 2030 with scaled-up treatment for selected mental disorders in Ukraine. The economic value of restored productivity over this period amounts to more than US\$800 million for depression and US\$350 million for anxiety disorders, which means that for every US\$1 invested in scaled-up treatment of common mental disorders in Ukraine, there will be US\$2 in restored productivity and added economic value.

If countries are serious about achieving Universal Health Coverage (UHC) by 2030, priority support is needed for integrating mental health services into existing health and social support service platforms. Engaging firms and enterprises, civil society, religious organizations, and affected people and their families in this effort will help to directly confront stigma and discrimination. Each incremental step taken forward at the regional and local levels toward improving access to timely and effective mental health services will make a difference in Ukraine—to affected persons, their families, at the work place, and for society at large. And it will contribute to build health capital, and hence human capital, to increase the total wealth of the country.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Bringing Mental Health Services to Those Who Need Them Most

Bringing Mental Health Services to Those Who Need Them Most



Submitted by Jaime Nicolas Bayona Garcia On Fri, 10/30/2015

Also available in: [Español](#) ^[1]



“Welcome to my house!” said World Bank Group President Jim Yong Kim during his opening remarks to the Peruvian President, First Lady, Minister of Health and Mayor of the district of Carabayllo. Dr. Kim felt like he was at home because he had been a regular visitor to Carabayllo since 1994, when he led an initiative to implement the first community-based approach to control multidrug-resistant tuberculosis (MDR-TB) in a resource-poor setting.

This time, Carabayllo was making history again. The President had recently signed a law that protected the rights of people with mental health problems. The regulation includes a set of community mental health services integrated at the primary health care level, which require the direct involvement of the community and the family of the patients. It is a first step to decentralize mental health services through the implementation of the new model of community care for mental health, including general and specialized care services for mental health.

Across six regions in Peru, there are 21 community centers for mental health. The coordinated effort—of the Ministry of Health, the National Institute of Mental Health, local government of Carabayllo, and several international and national organizations—is promoting social participation and is strengthening the network of mental health community-based approaches to implement psychosocial interventions in families with problems and mental disorders. In the past, mental health patients were hospitalized; now, in this new model of health care delivery, patients are ambulatory. The community health workers conduct home visits to beneficiaries and provide psycho-education, support adherence to treatment, and encourage the participation of family members in the recovery of the patient with mental health problems.

Anxiety and depression are common problems in Peru. In Carabayllo, as in other districts with high levels of poverty, social problems like domestic violence, sale and consumption of drugs, gangs, prostitution, assaults, and robberies are common. Community organizations in Carabayllo are trying to implement a comprehensive approach to deal with these complex challenges.

Efforts in Carabayllo include opening the first home for people with severe mental disorders in socially neglected situations. Six therapeutic caregivers, who are community health workers with ad-hoc training, are taking care of eight women, ranging from 21 to 63 years old. They are responsible for overseeing the treatment of the residents, for providing new skills training, and for enabling the socialization and reintegration of patients into the community. The National Institute of Mental Health is providing technical advice, training, monitoring and therapeutic support to caregivers.

As we left the district of Carabayllo, I thought about the great challenges the community is still facing to become a healthy society. Undoubtedly, the lessons from the past allow for an active community participation, creating a platform for true collaboration among government bodies and community-based organizations. With this new mental health initiative, Carabayllo once again—despite its persistent challenges—could become a model for innovation and learning, just as it was for MDR-TB.

The experience of Carabayllo convinced me that if we are going to fully embrace and support the progressive realization of universal health coverage, we must work to help bring mental health “out of the shadows” and into the mainstream of what is considered to be essential health care. To this end, we at the World Bank Group, in partnership with the World Health Organization, and with the support of an international, multi-institutional working group, are starting to work to build momentum and will co-host a major event on global mental health in spring 2016. Building on country experiences such as in Peru, the time has come to place mental health at the center of the global health and development agenda.

Follow the World Bank health team on Twitter: [@WBG_Health](#) ^[2]

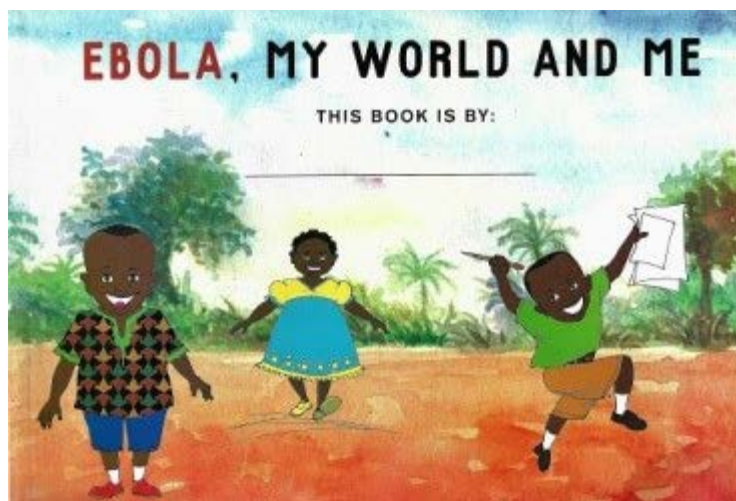
Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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In Liberia, providing comfort for kids in the aftermath of the Ebola crisis



Submitted by Rianna Mohammed-Roberts On Thu, 07/20/2017
co-authors: Sarah McCune



The Ebola Virus Disease (EVD) crisis ended more than a year ago in Liberia. It resulted in over 10,000 cases and 5,000 deaths. For many children, the crisis continues through intrusive memories of illness, isolation, and death. These memories are particularly acute for the children directly affected by Ebola; those that were quarantined, separated from family during treatment, or orphaned. The Liberia Ministry of Health (MOH) identified 3,091 such children, and a [World Bank working paper](#) ^[1] calculated that approximately 4,200 Liberian children lost one or both parents to Ebola.

[Protective factors](#) ^[2], such as a nurturing family life, dependable relationships, school attendance, and a stable political environment, can mitigate the negative psychological effects of a crisis, like Ebola. During the crisis, many of these protective factors were destroyed, leaving children vulnerable to experiencing further trauma. Left unaddressed, trauma can hinder children's academic achievement, and can increase their risk of compromised mental health later in life. Both of these consequences are known risk factors for poverty.

Recognizing the importance of addressing children's trauma, the Ebola Recovery and Restoration Trust Fund (EERTF) funded the implementation of a Comfort for Kids (C4K) program. The C4K program encourages psychological healing, and promotes resilience in children who have experienced a crisis or disaster. It was developed in the wake of September 11, 2001 by Mercy Corps, an international non-governmental organization, and has since been implemented following natural disasters in Haiti, China, and Japan; and in post-conflict and refugee settings in Gaza, Jordan, and Lebanon.

C4K primarily centers on the “My Story” workbook and associated classroom activities, which provide children with the opportunity to express their emotions about their experiences through drawing, writing, and facilitated discussion. C4K also provides capacity building for parents, teachers, and other caretakers on how to identify and more effectively respond to children’s trauma responses.

The C4K program in Liberia was implemented between January 2015 and December 2016 in 15 townships in Montserrado county. Approximately 10,000 children between the ages of six and 13 in 94 schools received “My Ebola Story” workbooks and participated in associated classroom activities, which were facilitated by 753 C4K-trained teachers. The workbooks were adapted to the Liberian context by local illustrators, who worked with C4K staff to ensure that they were age and content appropriate.

Workbook prompts asked children to draw the people in their lives who made them feel safe and loved, and circle the feelings—such as sadness, fear, hopelessness, and anger—that they experienced during the Ebola crisis. They also invited children to draw the daily activities that made them feel happy and to describe what they wanted to be when they grew up.

Teachers were enthusiastic about the program because they saw positive changes in their students’ behavior and mood. Students, they said, were more engaged and less despondent in class. Several teachers mentioned that the C4K program had prompted them to learn more about how to help children process their trauma. Also, to strengthen family bonds, and thereby increase children’s sense of security, teachers encouraged their students to share the workbooks with their parents. Program staff trained 612 parents on how to detect and respond to their children’s trauma reactions, and built the capacity of 280 health providers and 150 local leaders to further support the children’s recovery at the community level.

While implementing the “My Ebola Story” workbook and activities, teachers noticed that certain students were at high-risk for developing behavioral and emotional problems. C4K staff subsequently implemented a psychoeducation intervention targeted to 1,086 high-risk children and their families, and established a referral pathway to a Médecin Sans Frontières clinic for children in need of more intensive mental health services.

Time constraints did not allow for a randomized evaluation of the C4K program. However, pre- and post-test evaluation results show that the C4K program was successful in improving the psychosocial health and well-being of Ebola-affected children and in increasing community support for them. Prior to receiving the C4K workbook and participating in the associated activities, only 37 percent of children showed acceptable levels of psychosocial wellbeing; after participation, nearly 92 percent did.

Stigma and fear caused many adults to distance themselves from Ebola-affected children. Following their participation in C4K trainings, however, approximately 64 percent of adults were willing to support the children, up from 42 percent at baseline. Their behavior towards Ebola-affected children similarly improved. At baseline, 32 percent of adult participants reported that they treated Ebola-affected children with patience and understanding; after participation, 86 percent did.

These results, however, do not capture the complete story. Project stakeholders, including representatives from the Ministries of Health and Education (MOH and MOE), health providers, school principals, community and religious leaders, and members of parent-teacher associations have expressed overwhelming support for the program and a desire for its countrywide scale-up. While direct program expansion is severely constrained by a lack of resources, C4K staff and other development partners are now working with the MOH’s mental health division and the MOE’s teacher training, early childhood education, and psychosocial divisions to develop school-based mental health programs.

The C4K program was a small intervention. It was, however, an important first step to rebuilding the protective factors that can help Ebola-affected children to overcoming their trauma. These children are Liberia's future. Ensuring that they are psychologically healthy will contribute to Liberia's continued development.

END POVERTY IN SOUTH ASIA


Is technology the way forward for addressing mental health among youth?

SUBMITTED BY [VARALAKSHMI VEMURU](#) ON SAT, 08/12/2017

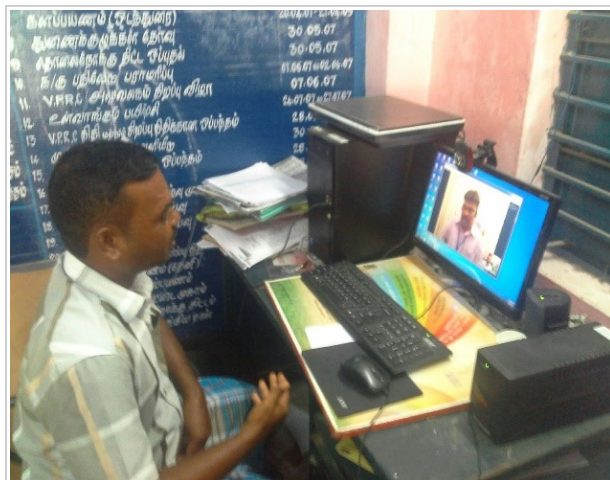
CO-AUTHORS: [SAMHITA KUMAR](#) 

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After an accident at his workplace, Bhoomi, a 26-year-old from rural Tamil Nadu, India, lost interest in work and isolated himself from everyone. His neighbors were at a loss to understand the change in his behavior. He was labeled a “lunatic,” which worried his parents and propelled them to seek help.


Mental illness or disability can be a debilitating experience for an individual as well as his or her family . People not only have to deal with the physical and biological impacts of an illness, but also with the social and cultural stigma that accompanies it.

This was what Bhoomi and his family went through before they benefited from the Tamil Nadu government’s [Mental Health Program](#) (TNMHP).




This community-based intervention, supported by the World Bank with Japanese Policy and Human Resources Development (PHRD) funds from 2012 to 2016, has used technology for not only disseminating information and raising awareness about mental illness and retardation, but also for expanding mental health care through tele-medicine and Skype.

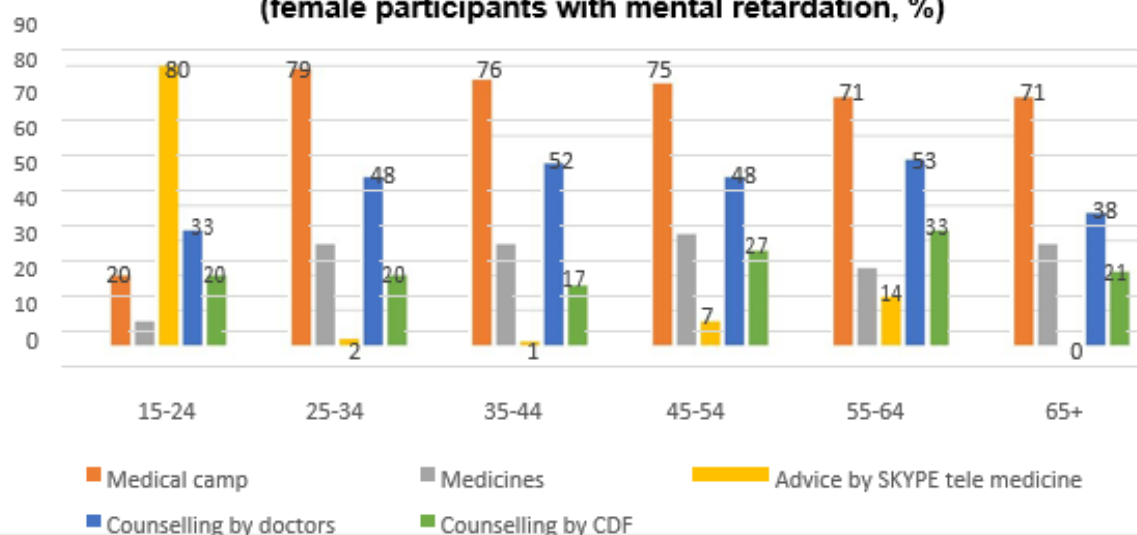
At first, TNMHP saw limited turnout from young people at medical camps. Then, in consultation with leading practitioners in Tamil Nadu, the project used technology to reach out to those who were reluctant but in need of care. Initial efforts showed that youth were comfortable seeking help through Skype.


Today, the advent of cyber cafes, internet facilities and mobile phones has made tele-medicine and skype less intimidating, and the use of technology is growing increasingly popular in mental health programs . A recent evaluation of the program shows that a stunning proportion of youth between 15-24 years of age (80%–100%), including girls, use skype or tele-medicine to seek help.

For women, however, this remains unfamiliar and daunting. The assessment found that only a small percentage of older women (6%) resorted to tele-medicine or Skype for treatment of mental illness or retardation, while a slightly higher percentage (10%) of men did so.

Still, technology can enable women to discuss highly stigmatized health concerns, including those related to mental health issues , with confidentiality and reassurance.

**Figure 1: Diagnostic & Treatment services availed by age group
(female participants with mental retardation, %)**



Skype and tele-medicine can also help overcome issues of physical access to services, especially in the health sector . Moreover, it can save on costs as a limited number of psychiatrists can cater to a larger number of people, in addition to reducing the social and cultural stigma.

Take the case of Radhika. Radhika lives with her parents in a remote village in Tamil Nadu. Not only did medicine prove to be too expensive for the daily wage agriculture labourers, but caregiving was time consuming. Radhika's mother stopped going to work to take care of her, dealing a severe blow to the family's income. Being able to seek expert help through Skype, and thus access high-quality mental health services helped Radhika recover and enabled her mother to go back to work.



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Tele-medicine under TNMHP has become possible due to doctors and nurses volunteering their time and expertise for addressing the physically, socially, culturally and attitudinally remote populations with much-needed support. Now, some creative thinking is required to tailor methods for different demographics and, for this, technology can be a major ally!

Published on *End Poverty in South Asia* (<https://blogs.worldbank.org/endpovertyinsouthasia>)

[Home](#) > Dawa-Dua: How medical treatment complements prayer for people with mental illness in India

Dawa-Dua: How medical treatment complements prayer for people with mental illness in India



Submitted by Varalakshmi Vemuru On Thu, 11/03/2016



Devotees at the Erwadi Dargah in Tamil Nadu, India. (Photo: DMPH Erwadi)

Last month I [blogged](#) ^[1] about how mental illness is curable, treatable, and preventable. Today, let me take you to a town in Tamil Nadu called Erwadi, where [faith and medicine now go hand in hand to address mental illness.](#) ^[2]

Erwadi is known for its 550-year-old Badusha Nayagam Dargah—“Erwadi Dargah,” one of the biggest shrines in India. Every day, numerous devotees of different faiths visit the shrine from surrounding villages, states, and countries. Among these visitors is a large number of people who suffer from mental illness and have come to pray for a cure. Some of them see the Dargah as their first and only hope—guided by the magico-religious belief that illness is caused by the possession of evil spirits or the performance of wicked magic—while others have turned to the shrine as a last resort after receiving ineffective treatment.

When I visited Erwadi Dargah in 2013 and met with a team working on a local program called [District Mental Health Project \(DMHP\)](#) ^[3], an important partner of the World Bank-supported Tamil Nadu Mental Health Project, they expressed an urgent need to help the devotees affected by mental illness. Their subsequent discussions with representatives of the shrine revealed a lack of information on potential treatment options and strong resistance to medical interventions among the devotees. At that time, the team knew of a similar circumstance in another part of India—the state of Gujarat—so they invited the

representatives of Erwadi's religious community to learn from peers in Gujarat about complementing religious rituals with medical treatment.

And thus started a unique experiment called "Dawa-Dua," or prayer-treatment.

Thanks to the visit to Gujarat, the religious leaders in Erwadi opened up to the idea of combining medical treatment with traditional healing. In 2014, Erwadi Dargah incorporated a clinic run by the DMHP within its premises and started offering its visitors access to professional psychiatric care, diagnosis, treatment, and medication. Patients were counseled to continue their prayers alongside professional medical treatment, and return for follow-up visits to improve their well-being.



Mental Health Institute of Erwadi. (Photo: DMHP Ramnad)

As a result of this initiative, over 3,000 people suffering from mental illness have been diagnosed and treated. Over one-third of them have made follow-up visits, while others have been referred to a general hospital or placed in the care of a newly constructed 50-bed hospital located on the territory of the holy site. A community rehabilitation center under the government-supported Community Mental Health Program has also been established to provide vocational training for patients, preparing them for integration into their communities.

When I visited the center earlier this year, a mother told me about her 26-year-old son: "For years, I have heard people calling my son mad and at the Dargah I have watched my son in chains. This program has truly been a gift of God. It has given both of us a new lease of life. My son now is normal like anybody else. I plan to go back home with my son soon." This was truly interesting given that many devotees believe that when the patient is cured by God, the chains come off!

Following the success in Erwadi, the State District Mental Health Program in Tamil Nadu has received requests from many other religious communities including three temples and two churches in Ramnad district alone, which is host to the Erwadi Dargah. These communities see an opportunity to help their significant number of devotees find an effective solution to mental illness.

This new prayer-treatment model, under the Tamil Nadu Mental Health Project, offers a unique opportunity to blend faith with medicine. It allows for medical practitioners and religious leaders to work alongside each other to find viable solutions to help those in need of mental health care. I hope that this experience can serve as an inspiration for other states in India as well as for other countries of how best to address the global challenge of mental illness within the local context.




- [About this series](#) [4]
- [More blog posts](#) [5]

Published on *People, Spaces, Deliberation* (<https://blogs.worldbank.org/publicsphere>)

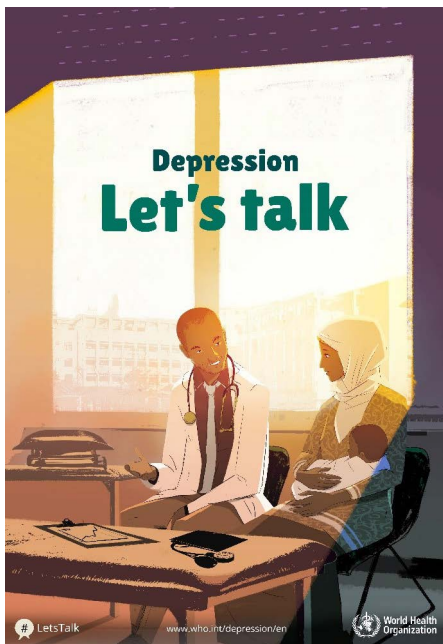
[Home](#) > Campaign Art: #LetsTalk

Campaign Art: #LetsTalk



Submitted by Darejani Markozashvili  On Wed, 03/29/2017

People, Spaces, Deliberation bloggers present exceptional campaign art from all over the world. These examples are meant to inspire.



[1]According to the World Health Organization [2] (WHO), globally more than 300 million people suffer from depression [3]. However, less than half of these affected seek and get help. In addition to stigma surrounding depression, one of the biggest barriers why people are unable to seek and get help is the lack of government spending worldwide for mental health services. "According to WHO's "Mental Health Atlas 2014" survey, governments spend on average 3% of their health budgets on mental health, ranging from less than 1% in low-income countries to 5% in high-income countries." [4]

Mental health needs to be at the forefront of the humanitarian and development agenda, in order to achieve the set Sustainable Development Goals [5] (SDGs). Governments around the world must scale up their investment in mental health services, as the current commitments are inadequate. The study published by **"The Lancet Psychiatry"** calls for greater investment in mental health services. "We know that treatment of depression and anxiety makes good sense for health and wellbeing; this new study confirms that it makes sound economic sense too," said Dr Margaret Chan, Director-General of WHO. "We must now find ways to make sure that access to mental health services becomes a reality for all men, women and children, wherever they live." [4]

In order to raise awareness about depression and encourage people from all over the world to seek and get help if they are

suffering from depression, in October 2016 the World Health Organization launched a one-year campaign called Depression: Let's Talk. Be sure follow this campaign using the hashtag #LetsTalk. The WHO has also made this issue the theme of the upcoming World Health Day 2017 (April 7).

For publications and available resources on depression, visit the World Health Organization [website](#) ^[6]. Find out how to [get involved](#) ^[7].

[Follow PublicSphereWB on Twitter](#) ^[8]!



5.

Reforming Health Systems: What to Do?

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Institutions and Systems Matter for Health and Social Development



Submitted by Patricio V. Marquez On Wed, 02/06/2013



This past week, I attended a couple of interesting seminars at the World Bank's Human Development Forum on how some mineral-rich countries have been able to translate their newfound riches into sustained economic growth, improved living conditions, and better nutrition, health and education levels for their populations.

The evidence from Chile (the largest copper producer in the world), Botswana (rich in diamonds) and Malaysia (blessed with oil), highlights the strong link between inclusive political and economic institutions and development. In large measure, these institutions are anchored in well-defined and accepted moral principles that govern the conduct, relationship, and interaction among individuals and groups within society. And, as a result, governments tend to be run in accordance with the rule of law, protecting and empowering their citizens to actively participate in the political and economic life of the nation, and helping people in need.

The democratic experience of Chile since the early 1990s offers a good example of how mineral wealth has helped develop and strengthen institutional and governance arrangements, not only to mobilize

additional government revenue through effective taxation policies on mining activity, but more importantly, how those increased public revenues are managed in a transparent manner in accordance with fiscal and budget laws.

Several policy changes in Chile illustrate this transition: Economic and social stabilization funds have been established to minimize the negative impact of fluctuations in copper prices on government revenues. In response to a new demographic scenario characterized by an increase in life expectancy and the growth of the senior citizen population, a Pension Reserve Fund was set up to guarantee basic solidarity pensions to those who were not able to save enough for their retirement. Investments have been made abroad to prevent the appreciation of the local currency that may undermine economic competitiveness. And new mechanisms, such as program budgeting, budget execution controls, and performance management, help guide funding decisions in sectoral ministries, controlling expenditures and assessing results achieved.

Reflecting social and political aspirations to construct more inclusive societies, Chile, Botswana and Malaysia have also increased social spending that over time have helped their citizens have more equitable access to health, education and social protection systems. For example, under Malaysia's 2006-2010 Ninth Development Plan, which recognized that "health is an important asset in the development of human capital", the government further strengthened one of the best health systems in Southeast Asia by promoting public/private integration for service delivery.

Botswana has done an effective job in controlling the spread of the HIV/AIDS epidemic by implementing prevention interventions, increasing access to voluntary testing and counseling services, and providing antiretroviral drug treatment to more than 90% of people who need it. As documented in a recent study, Chile's Regime of Explicit Health Guarantees, that mandates coverage by public and private health insurers of a comprehensive benefit package, has resulted in significant improvements in the early detection and treatment of chronic conditions, contributing to the high human development level ^[1] achieved by the country.

Overall, the combination of sound economic policies, strong institutions and a commitment to social development in these countries has helped reduce poverty and build the human capital needed to sustain economic growth, modernize institutions and systems, enhance job opportunities, and raise living standards.

Are these experiences relevant and applicable to other countries, particularly those middle-income countries that have been enjoying a mineral boom and rapid economic growth over the past decade but continue to be plagued by high levels of poverty and inequality and low human development indicators (e.g., far from meeting the key MDG targets such as reducing maternal mortality by 75% between 1990 and 2015)?

I would say the answer is a resounding yes. But all of us working in international development need to understand that to effectively support countries in operationalizing the social aspirations and goals of

governments and citizens, we need to strike a better balance between the pursuit of short-term “easy wins” or “results”, usually associated with traditional investment projects, and “medium- term engagement” approaches that are required to construct strong and effective institutions and systems.

This, in practice, implies that we need to transcend the “project mentality” and be ready to support institution- and system-building processes over the long haul, particularly by facilitating knowledge and experience sharing among countries. To do so with hope and persistence, we should be guided by Martin Luther King's words “The arc of history is long, but it bends toward justice.”

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Reforming health systems: leadership matters



SUBMITTED BY [PATRICIO V. MARQUEZ](#) ON WED, 11/16/2011



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I was in Tbilisi last week for the launch of Georgia's new five-year health strategy, "[Affordable and Quality Health Care](#)," the first strategy since 1999. It's a milestone in the country's ambitious health reform program, summarizing what has been achieved, the challenges ahead, and options to address them. And more importantly, the strategy reflects the government's commitment to continue redesigning the health system and improving the health status of the population through the adoption of multisectoral actions.

The Georgians should be proud. Since 2006, the government has radically transformed the health system, moving rapidly from a budget-funded direct provision of medical care in public facilities to subsidizing health insurance premiums for the poor. Private health insurance cum services providers, who are increasingly operating as integrated health management organizations, are delivering services in the benefit plan. The initial results are promising: Health insurance coverage has risen steadily from about 2 percent to 40 percent of the population, and out-of-pocket health care expenditures among the poor have been decreasing, particularly after a basic drug benefit was added to the health insurance plan.

You may say that the Georgian experience is nothing new because many countries across the globe have adopted or are adopting similar arrangements—and some countries have more to show. However, this experience shows us how unwavering leadership is a key to persevering on the sometimes rocky path of health system reform.

To be successful, health reform has to be defined and supported as a social imperative and development priority, with the government's full support. It's not just the responsibility of a ministry of health. Indeed, to be fully realized, health reform should embody and express the social values of the country and its aspirations for economic and social development.

With that articulated vision guiding policy making, strategic planning, resource mobilization and funding, communication and engagement with the public, and the management of program implementation, it's critical to have the capacity to stay the course, and develop and adopt heterodox approaches by engaging different stakeholders (as in the case of Georgia, private health insurance companies, foreign and local investors to modernize health services delivery infrastructure, regional and local authorities, physician associations, and civil society), as well as coordinated support from international and donor agencies.

Effective leadership also depends on the ability to be flexible in adjusting processes, investments and activities with new knowledge and experiences, without deviating from the broad vision. Flexibility is crucial but it must be backed up by evidence.

All of us working in international development should be mindful that more than simple technocratic solutions, effective and sustainable health reforms require specific leadership attributes. If we're going to be effective in supporting health reform efforts, we need to see the big social and political picture and avoid getting lost in discussions and proposals that are not fully articulated or embedded in the social fabric of countries.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Ethics, values and health systems

Ethics, values and health systems



Submitted by Patricio V. Marquez On Wed, 12/28/2011



It's widely accepted nowadays that the ultimate goals of a health system are to improve the health conditions of the population; minimize the risk of impoverishment due to catastrophic health events; and increase the level of satisfaction of the citizens of a country with the quality of services received.

What kind of health system needs to be developed to achieve these goals?

Professor Uwe E. Reinhardt, a distinguished Princeton University health economist, urges us to focus on broader social goals, including the distributive ethic or moral values in a country. In essence, this means that the “structural parameters” of a health system—financing health care, risk pooling to protect individuals from the cost of illness, producing and delivering health services, purchasing or commissioning health care on behalf of patients, stewardship and governance, and production and distribution of health care resources--should be determined by the shared ethic or moral values in a society.

As Professor Reinhardt points out, alternative “distributive social ethics” or “moral values” may offer three broad health care organization models to choose from: (i) a one-tier system, where health care is a social good available to all on equal terms; (ii) a two-tiered system, where health care is a social good for all with exception of the rich; and (iii) a multi-tiered system, where health care is a private consumption good like other services such as food and housing.

So which one of these models should governments adopt, adapt and develop? Which model should international organizations recommend as part of policy dialogue with governments? Is there an appropriate “government” versus “private market” combination that should prevail in a health system?

These questions perhaps are not very relevant for policy making or to ensure efficient allocation and use of scarce resources since we may run the risk of confusing “means” with “goals”. What is needed first is a better articulation and definition of a country’s social goals.

These debates have been taking place across the world: For example, in the United States, around the mandate that requires everyone to purchase health insurance to prevent healthy people from opting out; in Russia, around how to protect people from the impoverishing impact of out-of-pocket expenditures for medications; and in South Africa, on a proposed new health insurance scheme.

It is clear from these debates that how a health system is structured reflects decisions on what kind of society a country wants to have.

We have to be mindful that the definition of broad social goals ultimately guide policy and institutional decisions concerning the most appropriate and contextually relevant organizational forms, health care financing arrangements, and service delivery mechanisms that could be adopted to attain the intermediate goals of a health system (improved access, quality, efficiency, and fairness), which contribute to achievement of the ultimate goals of a health system (improved health status, financial protection, and patient satisfaction with health care received).

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > The imperative of integrated health care delivery systems

The imperative of integrated health care delivery systems



Submitted by Patricio V. Marquez On Mon, 12/05/2011



[1]

In the past decade we have witnessed a noticeable zigzag internationally on how to improve health system performance. While some have advocated for the primacy of primary health care (reinforced by a major [2008 WHO report](#) ^[2]), others have stressed the importance of hospital autonomy initiatives.

This zigzag clearly illustrates another false dichotomy in the health sector that merits urgent revision. More and more, we're recognizing why a cohesive and integrated health care delivery model needs to be in place to better organize and respond to the changing needs of the population, particularly given the raising importance of noncommunicable diseases and injuries as the main causes of death and disability worldwide. A recent [report on NCDs in China](#) ^[3] demonstrates how the chronic nature of these conditions—different from acute episodes of ill health resulting from infectious diseases—demands a well-coordinated combination of hospital, ambulatory and physician response, in some cases over the lifetime of an individual.

We need to take technological and financial imperatives into account, too. For example, procedures that used to require lengthy hospitalization now can be performed in an outpatient facility, thanks to new technologies with more convenience and safety for the patient. The financial realities across the world demand reductions in the avoidable costs of untimely, uncoordinated, expensive and substandard care.

How can we support the development of integrated care? Evaluated experiences in countries provide evidence: Kaiser Permanente and the Veterans Administration models in the United States; Trafford, a Greater Manchester borough of 215,000 people in England; the Chuvash Republic in Russia; the evolving privately run health management organizations model in Georgia; and more recently, the promising wider health care network established in Lesotho, a small country with significant health challenges in Africa.

These experiences show how the integrated care model embodies community-based primary, general acute medicine, specialist outpatient and diagnostic care, and referral hospitals.

The core of the model should be planned care in accordance with each population's health needs. Integration is realized either through "vertical integration" of public facilities by developing agreements with unified goals and incentives, or "virtual integration" through contracting modalities that link public and private insurance companies and service providers. The critical enabling tools are de-concentrated or decentralized decision-making and management structures and processes, as well as the use of evidence-based clinical protocols to guide care coordination; health management information systems to coordinate the on time flow of patient and administrative and financial information across facilities; and new incentive frameworks that link resource allocation or payments to the production of quality services and good health outcomes.

Perhaps the time has come to ditch commonly accepted dichotomies and embrace more cohesive delivery system approaches by putting patients' needs at the core of our work.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

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Sub-Saharan Africa: How can we avoid the disease silos trap?



Submitted by Patricio V. Marquez On Tue, 09/18/2012
co-authors: Jill Farrington



While much of the health focus in sub-Saharan Africa has been directed toward communicable diseases, particularly HIV/AIDS, there has been less acknowledgement that non-communicable diseases (NCDs) are a growing problem. These diseases already account for about 30% of deaths and are expected to become the leading cause of ill health and death by 2030 ([see chart \[1\]](#)).

In a [recent article \[2\]](#) for the British Medical Journal, we focus on the complex health burden in sub-Saharan Africa, and ask how the region might respond to this challenge.

We argue that the long-term care needs of chronic diseases, both communicable (as more people benefit from antiretroviral drug treatment, HIV/AIDS is fast becoming a chronic condition) and NCDs, threaten to overwhelm fragile health systems, and propose three strategies to alter this course:

First, capitalize on the inter-linkages between conditions and on their common determinants. Not much attention has been paid to the extent that communicable diseases contribute to the onset of NCDs and to potential common interventions. Around one-third of cancers in Africa are infection-related; for example, human papilloma virus (HPV) causes cervical cancer, a leading killer of African women, and HPV-associated cancers occur more frequently in HIV infected people. Diabetes triples the risk of developing tuberculosis (TB) and is a common co-morbidity in people with TB.

Some interventions to prevent NCDs are straight out of the communicable disease toolbox. Immunization programs could be expanded to provide HPV vaccines for young girls and protect them against HPV types which cause 70% of cervical cancer cases. Collaboration with reproductive and sexual health programs could help raise awareness of early signs and symptoms of cervical and breast cancer and increase coverage of low-cost cervical cancer screening and treatment programs.

Second, focus on common care needs, rather than disease categories. Interest is growing in how the resources, experience and models used for communicable diseases, such as scale-up of antiretroviral therapy treatment for AIDS, and the DOTS Framework for TB, can be used for the benefit of NCDs, as well as in how chronic care models commonly used for NCDs can support HIV care and treatment.

Third, capitalize on existing resources and capabilities. There is potential for redesigning the delivery of services around multidisciplinary teams to facilitate task-shifting among personnel and bringing care closer to the patient. Other approaches include using common procurement and supply lines for getting essential drugs to remote clinics and scaling up the use of new technologies, such as mobile phones and integrated health information systems. Linking health spending decisions to adoption of clinical guidelines for service provision would encourage coordination of care and improve the quality of services.

Much of the illness burden and inefficient use of resources could potentially be avoided. But to do so, both governments and the international community need to prioritize building health systems that offer universal financial protection against the cost of ill health, along with improved access to quality services, to deal with the multiple health needs of the population, rather than only a few specific diseases.

An effective response should also include multisectoral actions (for example, higher excise taxes to make tobacco products less affordable) for dealing with disease-related risk behaviors in the entire population.

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[Home](#) > HIV/AIDS: A Linchpin for Universal Health Coverage

HIV/AIDS: A Linchpin for Universal Health Coverage



Submitted by Patricio V. Marquez On Mon, 12/01/2014



As we honor World AIDS Day 2014, perhaps it is time to pause and take stock of the gains achieved over the last three decades by the extraordinary social movement that emerged across the globe to confront HIV.

While denial and stigma still lurk at the fringes, widespread progress has been made in the fight against the AIDS epidemic. Although today there are more than 35 million people living with HIV, UNAIDS data show that by June 2014, some 13.6 million people in need had access to antiretroviral therapy (ARV), a huge step towards ensuring that 15 million people have access by 2015.

This undoubtedly has contributed to the 35% reduction in AIDS-related deaths observed since their peak in 2005 and to quality-of-life improvements among HIV-infected people. Deaths due to tuberculosis, the leading cause of death among people living with HIV, have also fallen by 33% since 2004, and new HIV infections have dropped by 38% since 2001.

Although some people continue to argue that the unprecedented attention and funding for HIV have created a major imbalance in the global health agenda by reinforcing a “vertical program” orientation, we should remember that in previous decades, the reality of weak and under-resourced health systems in most of the world and limited access to basic health services for the majority of the population were common phenomena before the AIDS response.

This reality has been made evident again with great clarity by the current Ebola outbreak in West Africa.

Significant investment in health systems in low- and middle-income countries have been made over the last decade, for scaling up HIV prevention and clinical care as well as for integrated care approaches for tuberculosis and HIV. Given this, I think it is good to ask how we could advance universal health coverage, leveraging the resources, experience and models of existing HIV and AIDS prevention and treatment programs to manage other chronic health conditions.

As discussed in recent papers ([HIV and Noncommunicable Disease Comorbidities in the Era of Antiretroviral Therapy: A Vital Agenda for Research in Low- and Middle-Income Country Settings](#) ^[1], [HIV, Tuberculosis, and Non-communicable Diseases: What Is Known About the Costs, Effects, and Cost-effectiveness of Integrated Care?](#) ^[2]), this is an important point to keep in mind since HIV-infected individuals are now not only living longer as a result of the expansion of antiretroviral therapy programs, but are also developing chronic, non-communicable diseases (NCDs), such as cardiovascular diseases and cancer, due to a mix of chronic immune activation, medication side effects, co-infections, and the aging process itself.

Botswana, one of the countries hardest hit by HIV, and a leader in the AIDS response in Southern Africa, offers a good example of how governments could leverage HIV and AIDS services and programs to integrate and add NCD prevention and treatment into existing services and programs to integrate and expand access to services for other priority health conditions.

Faced with resource limitations that have hindered the expansion of cytology laboratory-based screening for cervical cancer—one of the leading causes of premature death among women, particularly those who are HIV-positive—the government of Botswana started to introduce at AIDS clinics in 2013, lower-cost but equally effective “see and treat” screening procedures, along with cryotherapy to destroy abnormal tissue in the cervix by freezing it.

This approach will help overcome the current limited laboratory screening capacity for cervical cancer which results in a significant number of patients diagnosed with advanced or terminal stage disease. Since the high incidence of cervical cancer in Botswana is linked to a sexually transmitted infection caused by the human papilloma virus, the targeted use of HIV prevention interventions -- such as the promotion of safe sex, use of condoms, avoiding harmful use of alcohol, and male circumcision -- are also likely to help prevent cervical cancer, along with HPV vaccination for school-age girls. Such vaccinations began to be rolled out in 2013 as part of the country’s Expanded Program for Immunizations.

Additional investments are being made to improve cervical cancer data collection in health facilities as part of the development of an electronic health information system being rolled out across Botswana, as well as to support the establishment of a national cancer registry.

These system-wide measures show that it is possible to continue supporting investments and activities to achieve the ambitious goal of ending the AIDS epidemic, while building integrated health services delivery platforms to cover a wide array of diseases with similar prevention and care needs, including palliative care. This approach will also help capitalize on existing resources and capabilities, facilitate task-shifting among personnel and the use of common procurement and supply lines for getting essential drugs and other materials to health facilities, and introduce and scale up the use of new technologies, such as mobile phones and integrated health information systems.

Linking health spending decisions to adoption of clinical guidelines for service provision would further encourage coordination of care and improve the quality of services.

The important catalytic role that the HIV and AIDS response has played in the development of a robust global health agenda and increased funding for health programs over the last decade needs to be acknowledged. But it should also be recognized that supporting the development and strengthening of health systems in the future under the universal health coverage agenda -- including stronger primary health care networks, integrated chronic care services delivery and community-based interventions that focus on the person as a whole rather than on disease categories -- will facilitate opportune access to quality health services for all.

Follow the World Bank health team on Twitter: [@worldbankhealth](https://twitter.com/worldbankhealth) ^[3]

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Are all medical procedures, drugs good for the patient?

Are all medical procedures, drugs good for the patient?



Submitted by Patricio V. Marquez On Mon, 03/05/2012



Also available in: [Русский](#) ^[1]

When healthcare professionals take the Hippocratic Oath, they promise to prescribe patients regimens based on their “ability and judgment” and to “never do harm to anyone”.

Although extraordinary progress in medical knowledge during the last 50 years, coupled with the development of new technologies, drugs and procedures, has improved health conditions and quality of life, it has also created an ever-growing quandary regarding which drugs, medical procedures, tests and treatments work best.

And for policy makers, administrators and health economists, the unrestrained acquisition and use of new medical technologies and procedures (e.g., open heart surgery to replace clogged arteries, ultrasound technology scanners to aid in the detection of heart disease, and life-saving antiretroviral drugs for HIV/AIDS) is increasing health expenditures in an era of fiscal deficits.

In many countries, I’ve seen how ensuring value for money in a limited-resources environment is not only difficult but requires careful selection and funding of procedures and drugs. It also comes with serious political, economic and ethical implications—and with new drugs and technologies appearing every day, this challenge isn’t going away. What should countries do?

As they look for new approaches to improve the access to and quality of medical and public health services while minimizing escalating costs, some are reviewing and adapting best practices for preventing, diagnosing and treating diseases and injuries. For example, the United Kingdom National Institute for Health and Clinical Excellence (NICE) appraises new drugs, medical devices and diagnostic tests before funding them in the National Health Service.

With the support of World Bank projects, countries such as Georgia, Romania, Turkey, Tunisia and Jordan are initiating similar efforts with the participation of NICE teams. In Georgia, for example, we helped develop clinical guidance for cardiovascular diseases. Colombia is also establishing structures to appraise drugs, and China and Russia are adapting evidence-based clinical guidelines to their specific institutional realities. And under the new U.S. healthcare reform law, as of 2012, the government is requiring health insurance plans to find out which drugs, medical procedures, tests and treatments are the most effective and efficient.

Countries should consider emulating these experiences because scientific evidence is not only a critical tool to improve treatment and spending decisions—it also helps build capacity to adapt new knowledge and technologies that ultimately benefit people.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > An imperative: reforming medical and public health education

An imperative: reforming medical and public health education



Submitted by Patricio V. Marquez On Mon, 11/07/2011



[1]

My recent work in Azerbaijan convinced me that reforming medical and public health education programs is critical to revamping clinical processes and public health practices for effective prevention, diagnosis and treatment of diseases and injuries. In this small Caspian Sea country, improving physicians, nurses and public health specialists' educational programs—which are hampered by outdated conceptual and methodological structures and practices—is starting to receive priority attention in the country's quest to improve health system performance.

The challenge is shared globally, as different countries are struggling to sufficiently staff their health systems with well-trained, deployed, managed and motivated physicians and nurses to provide quality medical care, and competent staff to manage service delivery and carry out essential public health work such as disease surveillance.

With few exceptions, such as the [2010 Lancet commission report](#) [2]*, medical, nursing and public health education reform has failed to appear in the international health agenda—yet we continue to focus on employment and remuneration of existing personnel. This has to change. Why? Simply because the adoption of and adaptation to local conditions of new knowledge, country experiences and good practices help accelerate social and economic development.

The extraordinary progress in medical knowledge during the last 50 years, coupled with the introduction of new technologies, drugs and procedures, and the promise of more profound and rapid changes in the future catapulted by the “genome revolution” and evidence from different disciplines, clearly point out that medical and public health education programs cannot remain static. They need to continuously change with these developments and serve as the “conduit” for channeling new knowledge to reform medical and public health institutions and practices.

Education reform requires well planned and systematic efforts. In Azerbaijan, the Ministry of Health and the State Medical University, with the support of the Royal Society of Medicine and Barts and London Medical School, initiated the revision of the fragmented medical education curriculum by defining aims, outcomes and structure of the whole program, for each year, and for core modules. The country is also adapting new learning and training materials in the local language; introducing laboratory training (e.g., bedside teaching, using equipment) to develop the clinical skills of students; replacing oral examinations with test-based assessments to objectively measure student performance; supporting training to improve the knowledge and teaching skills of professors; and introducing a national licensing examination for recent graduates to determine who is fit to practice medicine.

Similar efforts are underway for post-graduate medical training through the introduction of residency programs for specialists. In January 2011, a mandatory accreditation process began with the standardized, computer-based testing of practicing physicians for the issuance of medical licenses. The effort to reform medical education will need to be accompanied in the future by similar reforms in nursing and public health education.

It is too early to measure the impact of the education reforms in Azerbaijan, but other countries may do well by emulating this experience. And international organizations and donors need to support this effort not only to help ensure that future physicians and nurses, as well as public health specialists, are well prepared to tend the health needs of the population, but to sustain ongoing health care organization and financing reforms.

* “Health professionals for a new century: transforming education to strengthen health systems in an interdependent world.” The Lancet, Volume 376, Issue 9756, Pages 1923 - 1958, 4 December 2010. ^[2]

Published on *AfricaCan End Poverty* (<http://blogs.worldbank.org/africacan>)

[Home](#) > How can we improve access and get more value from drug expenditures in Africa?

How can we improve access and get more value from drug expenditures in Africa?



Submitted by Patricio V. Marquez On Mon, 10/22/2012



Medicines are key inputs for quality medical care and the prevention of disease, and when administered appropriately, as evidence from Sub-Saharan African countries shows, they can contribute significantly to reducing death rates due to conditions such as HIV/AIDS, tuberculosis, and malaria.

But it is also obvious that not everybody in these countries, particularly the poor, enjoys this benefit, since limited access to essential drugs remains a key challenge in most health systems. High out-of-pocket expenditures, typically more than 40% of total health expenditures in some countries (a large portion for outpatient drugs), also place a heavy burden on poor families with chronically ill members who require daily drug intake.

Facilitating effective access to essential medicines at an affordable price has been a long-standing aspiration of governments across the world. This challenge has become more acute nowadays given the negative impact of the global economic downturn on public budgets that constrain health spending and development aid.

I think that to effectively deal with this challenge, countries need to reinforce the adoption of an essential drugs benefit for the most prevalent diseases, ensuring that decisions about what drugs are included on essential drugs lists and likely volumes are costed, and that the full implications of listing every new drug are taken into account.

But where should additional resources come from to finance this benefit?

An obvious option is to redirect public expenditures toward long-term needs of social sectors such as health, and away from less productive categories of public expenditures (for example, general administration expenditures, or untargeted subsidies and transfers). Another promising option is to increase excise taxes on cigarettes to pay for the drug benefit and improvements in the supply chain for drugs. This option is not only consistent with the Framework Convention on Tobacco Control, which most countries in Sub-Saharan Africa have ratified, but also would have the effect of raising prices to make cigarettes less affordable, encouraging tobacco users to quit and contributing to a reduction in the high cost of treating tobacco-related chronic diseases in the future.

The adoption and implementation of stronger tobacco taxation policies in Sub-Saharan Africa to generate additional funds for health programs is indeed feasible, since 30 out of 46 African nations have a tobacco

taxation rate lower than 40% as compared to only 5 out of 53 European countries, or to some Latin American countries, where the rates range from 56% in Costa Rica, 65% in Mexico, and 76% in Chile. A good international example of the application of this option is the decision in February 2009 by the US Government to renew and extend the Children's Health Insurance Program (CHIPRA) for low-income uninsured children, financed by a 62-cent per-pack increase in the federal cigarette taxes and other tobacco tax increases.

Some people may argue that this type of proposal will only aggravate an already bleak situation ^[1] given significant evidence that government-provided drugs are stolen (usually by health workers) and sold on the open market, which makes it even harder for poor people to get access to them. Yes, that happens, and the problem is part of institutional weaknesses in the health sector in many countries. But at the same time, there is significant evidence of success stories in other countries.

So, besides adequate funding, it is imperative that ongoing efforts be supported to build resilient institutions and systems to facilitate access to and promote the rational use of medicines.

For example, in Nigeria, as recently reported in The Economist, the government has adopted measures such as a scratch-off label system that have reduced the flow of counterfeit medicines from around half to a tenth in five years. Stronger supply chains for lifesaving drugs—including hiring district-level planners to help manage orders and deliver drugs more efficiently—have proved very effective in Zambia, where pediatric malaria drugs, essential to save children's lives, have become available in 88% of public health centers in pilot districts, nearly doubling the 51% availability rate in control districts.

Results presented at the 2012 Clinton Global Initiative, showed that in Tanzania, the Medical Stores Department (MSD), leveraging Coca-Cola's expansive distribution system and supply chain expertise, has reduced the delivery times for anti-AIDS drugs and vaccines in 10 rural regions from 30 days to five. Now, the initiative is going to be expanded to cover 75% of Tanzania and include Ghana and Mozambique.

Given the ever-growing number of drug therapies, the lack of access of many physicians to scientific information or enough technical knowledge for making a critical appraisal of new medicines, the adoption of clinical guidelines for specific diseases as done in Botswana is helping improve prescription patterns of physicians avoiding tendencies to overmedicate with little or no benefit for the patient. Equally important are methods to ensure adherence of patients to the prescribed drug regime, such as the directly observed treatment for tuberculosis, that helps prevent the development of drug resistance.

As the implementation of the universal health coverage agenda evolves across African countries, proper attention needs to be placed to ensure timely access to essential medicines taking into account international experiences and ongoing innovative efforts in the countries. The policy decisions that could be adopted in this area will be of crucial importance to improve resource utilization and generate better health outcomes.

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[Home](#) > Health information systems in developing countries: Star Wars or reality?

Health information systems in developing countries: Star Wars or reality?



Submitted by Patricio V. Marquez On Mon, 07/16/2012



[1]

In the late 1990s, an international consultant told me that a proposed electronic health information system in the Dominican Republic was “like Star Wars and will not work in this country.”

Our objective was to improve service delivery by virtually connecting health providers to share medical records with one another as patients moved from health centers to hospitals. We learned that this was much more than an overnight task, requiring a sustained medium-term effort by the government to get the system fully up and running.

In recent years, I’ve seen similar efforts realized in the Russian Federation, Georgia, Azerbaijan and Botswana. In two Russian regions, Chuvash Republic and Voronezh Oblast, for example, electronic records are helping coordinate the flow of clinical and financial information across the health systems as facilities, departments within hospitals, and health insurance agencies have been “virtually” connected

through broadband networks. The electronic records are supporting clinical decision-making, facilitating performance measurement and pay-for-performance initiatives, and ultimately the continuity of care as patients move across the health system. Inter- and intra-regional medical consultations and distance learning activities are also being supported by telemedicine networks that connect specialized hospitals with general facilities.

In Georgia, the Social Information Management System (SIMS) at the Ministry of Labor, Health and Social Affairs is providing consolidated automated information about all the registered beneficiaries (each with a unique identifier) of government-funded social programs. This has improved management of the Mandatory Health Insurance for the Poor (MIP) and other programs, such as pensions, means-tested targeted assistance, and internally displaced person allowance distribution, bringing transparency in the use of public funds.

In Azerbaijan, electronic case reporting forms, supported by geographic information systems, is helping track and fight, in real time, communicable disease outbreaks.

And in Botswana, the government has rolled out an electronic medical records system to all of the country's main hospitals, and the country continues to improve the coding and reporting of health conditions and internet connectivity.

These examples from countries clearly show that in reshaping the global health agenda, we need to support the spread and local adaptation of health information technology and overcome the thinking that implementing this information and communications technology is beyond the capacity of countries at different levels of development.

The Star Wars movie saga was entertaining science fiction, but transforming health service delivery in countries is not. Helping deploy the power of electronic health records is not only environmentally friendly (less paper-based medical records), but it has the potential to transform the decision-making capacity and the quality of services in the health system of a country.

Published on *Investing in Health* (<http://blogs.worldbank.org/health>)

[Home](#) > Regional Disease Surveillance in a Globalized World

Regional Disease Surveillance in a Globalized World



Submitted by Patricio V. Marquez On Wed, 12/17/2014



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As we close the chapter on 2014, which is likely to be remembered in history as the “year of Ebola,” it is worth drawing some initial lessons for the future.

While the epidemic in West Africa is still evolving, despite progress made over the last few months, this global health crisis has made evident at a very high human, social, and economic cost the imperative of investing and sustaining disease surveillance systems as a priority “global public health good.”

Let’s be clear: globalization is not going to wither away, as it has been part of human history for millennia. Rather, we are and will continue to live in an increasingly interconnected world. While there are multiple benefits from globalization, there are also public health risks that are associated with demographic and economic pressures on ecosystems that facilitate the transmission of new pathogens from animals to humans. These zoonotic diseases account for 70% of emerging infectious diseases.

As we have seen recently with Ebola, an infectious disease of animal origin, and before with SARS and Avian Influenza, viruses jump and spread across borders without passports, wreaking havoc in their wake among

unsuspecting populations, countries, and continents. This situation is becoming more challenging as the increased movement of goods, services, and people across the world facilitates the rapid spread of infectious diseases.

Perhaps one of the best antidotes for countries to be ready to detect early, identify rapidly, and respond effectively to future outbreaks like Ebola, is to learn from this and past health crises across the world and to adapt the lessons of what has worked well and not so well. Indeed, tapping into a vast global knowledge repository to help build resilient health systems should be seen as one of the great benefits of globalization that cannot be overlooked or simply wasted.

While the 2005 International Health Regulations (IHR) that came into effect in 2007 mandate that countries use existing national structures and resources to develop and maintain capacity for disease surveillance, reporting, notification, verification, response and collaboration activities, evidence from efforts to establish and expand regional disease surveillance networks -- such as those in the Mekong Basin, East Africa, Southeastern Europe, Southern Africa, or the Asian Partnership -- demonstrates that cooperative arrangements among neighboring countries can control cross-border disease outbreaks at their source and improve health outcomes.

As documented in the summary article* of a special issue of the *Emerging Health Threats* Journal**, the establishment of regional disease surveillance networks can add value by:

- Complementing global and country disease surveillance systems, particularly by helping address the lack of or limited surveillance capacity in countries, their limited diagnostic capabilities, and disincentives to reporting due to fear of economic consequences.
- Harnessing network power, not only to implement the IHR by upgrading national surveillance systems and supporting standardization of definitions, detection, and reporting, but more importantly by prioritizing building trust-based relationships that facilitate informal reporting and sharing of sensitive information, and enabling cross-border collaboration and the strengthening of national technical capacity.
- Helping national institutions adapt to changing conditions and needs associated with infectious disease spread, which require multinational, multi-sectoral, and multi-disciplinary solutions.
- Establishing networks that foster local leadership and action and collaboration among national public health institutions and research and training centers.

As Ebola-affected countries in West Africa and the international community continue to strengthen the response to the epidemic to achieve the goal of zero Ebola cases, perhaps the establishment of a West Africa-wide regional disease surveillance network should be high on the priority “to do” list for the medium term, to bring together not only the affected countries but also neighboring countries, since infectious diseases do not respect national borders.

Moreover, working in accordance with “One Health” principles, the region will be in a better position to detect early, prevent, respond, and mitigate the impact of outbreaks of infectious diseases, both new and endemic, by linking public health, veterinary and environmental services, as well as to deal with anti-microbial resistance.

For a regional disease surveillance initiative to succeed and be sustainable over time, two critical ingredients are required (i) active leadership, engagement, and funding support of national governments and international agencies, coupled with continuity in the participation of individuals and institutions to gradually establish a basis of shared knowledge, trusted communication, and experience; and (ii) the ability to leverage and build upon existing governance structures and initiatives, and connect national public health institutions, training, and research centers in the region.

As the saying goes, a crisis poses challenges but also offers opportunities to learn and evolve. All of us in the global health community have an obligation not only to learn from the current Ebola crisis and what has worked elsewhere but to avoid, paraphrasing the Harvard philosopher George Santayana, being condemned to face *unprepared* similar crises in the future.

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[Home](#) > Integrated Community Case Management: How Can We Ensure Its Sustainability?

Integrated Community Case Management: How Can We Ensure Its Sustainability?



Submitted by Patricio V. Marquez On Thu, 03/27/2014



Recently I was part of a panel at an international symposium on Integrated Community Case Management (iCCM) that was held in Accra, Ghana, and hosted by UNICEF and other organizations, including the World Health Organization (WHO), U.S. Agency for International Development (USAID), Gates Foundation and Save the Children. The goal of the panel was to consider the role of partners in sustaining iCCM, in particular in supporting countries and their governments to scale up, deliver and fund iCCM.

The group agreed that iCCM helps increase access to treatment to those beyond the reach of health facilities and has the potential to more equitably address the main causes of child mortality such as pneumonia, malaria and diarrhea. iCCM also offers a way to deal effectively with other conditions such as neonatal infections, child malnutrition and neglected tropical diseases, like onchocerciasis. In the iCCM model, community health workers (CHWs) are identified and trained in diagnosis and treatment of key illnesses and also in identifying those in need of immediate referral to health facilities and specialized personnel.

In looking forward to the post-2015 MDG period, the critical questions on everyone's mind are: How can iCCM be scaled up in a way that ensures quality of service and increases demand? How can we assess the costs and evaluate the impact of such strategies to ensure that we are best supporting progress on child mortality and balancing needs with other pressing challenges such as malnutrition and maternal mortality.

As I noted in my comments during the Ghana panel, rather than a “vertical strategy”, iCCM should be seen as key component of an integrated health response to the multiple health needs of the population along an interconnected continuum: from health promotion, disease prevention, treatment and care, to rehabilitation.

The use of community platforms and CHWs can also be leveraged as part of intersectoral approaches to tackle the social determinants of health (e.g., poor living and working conditions, lack or limited access to basic services), behavioral and biological risk factors (e.g., smoking, alcohol abuse, high blood pressure), and cultural misconceptions about health problems that influence the risk for, or vulnerability to, both communicable and non-communicable diseases and injuries.

Integration of iCCM within broader systemic arrangements requires additional effort at the policy level. If one takes into account iCCM benchmark components (coordination and policy setting; costing and financing; human resources; supply chain management; service delivery and referral; communications and social mobilization; supervision and performance quality assurance; and monitoring, evaluation and health information systems), it is clear that institutionalization is key. That is, the scaling up and sustainability of iCCM requires that it becomes institutionalized, or fully incorporated into national priorities, policies, and programs, with corresponding funding and capacities to sustain it.

Institutionalization of iCCM also requires evidence-based frameworks to conduct a more systematic look at questions such as: How are the interventions in “health packages” selected? How often are the analyses updated? Are local data used? What are the innovative service delivery models that leverage both internal and external actors and resources that should be replicated? How are decisions reached based on evidence, and how is that evidence translated and adapted to specific institutional, cultural and fiscal realities of the countries?

So, where does iCCM fit with regard to the current and future drive to move towards universal health coverage, which the World Bank is strongly championing? The answer is simple. First, iCCM is a critical strategy to achieving equity objectives—for reaching the last 20% of people in remote regions or areas, or in refugee camps, that are hard to access due to poor roads, lack of transport and infrastructure, civil unrest or conflict.

Equally important, the institutionalization of iCCM can contribute over the medium term to sustain access to a continuum of services to poor and vulnerable population groups, particularly in rural and peri-urban areas, to offer both disease prevention interventions such as mass drug administration, alongside distribution of bed nets, micronutrients, or chemotherapy for seasonal malaria, and refer them for treatment of diseases and their co-morbidities.

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6.

**A “Pentavalent” Approach
for Financing the Global
Scale Up of the Mental
Health Agenda**

Published on *Investing in Health* (<https://blogs.worldbank.org/health>)

[Home](#) > On World Mental Health Day: A call to invest in interventions for young people

On World Mental Health Day: A call to invest in interventions for young people



Submitted by Patricio V. Marquez On Mon, 10/08/2018
co-authors: Sheila Dutta



Image: WHO World Mental Health Day 2018

Many of us have vivid memories of the joy and excitement of young adulthood, but this can also be a time of stress, apprehension and fear of the unknown. For many young people, this unease can lead to acute anxiety, severe depression or substance use disorders, if not recognized and managed.

Young people living in environments where they face death and suffering daily, such as in West Africa during the Ebola epidemic of 2014-2015, in post-tsunami or earthquake-affected areas, or in countries experiencing extended conflict and violence, are particularly vulnerable to mental distress and illness.

This year's World Mental Health Day, on Oct. 10, recognizes this critical time in life with the theme "Young People and Mental Health in a Changing World." Many changes occur during adolescence and the early years of adulthood, but they are not always acknowledged or treated.

The recent flurry of activity on global mental health, including the Global Ministerial Mental Health Summit hosted by the U.K. Government on Oct. 9-10, 2018, has been promising for addressing some of these concerns. However, there's still much to be done.

According to the Institute for Health Metrics and Evaluation (IHME) ^[1], mental and substance use disorders account for 18.9% of years lived with disability (YLDs) worldwide. While effective prevention interventions and treatments exist, the scale of untreated mental conditions affecting young people and adults in communities (as well as in prisons) is severe and widespread globally. Worldwide, it is estimated ^[2] that 10–20% of adolescents experience mental health conditions, yet these remain underdiagnosed and undertreated. Among the population as a whole, around 80% of people with severe mental disorders in low- and middle-income countries and 40% in high income countries ^[3] receive no treatment. The inaction to adopt and sustain scaled up efforts to make mental health care accessible for those in need, as an integrated part of health systems and other social support programs, contributes to challenges that affect society at a very high economic cost: school dropouts; alcohol and drug addiction; isolation and homelessness; increased likelihood of being arrested for a crime; and self-harm.

Confronting the health and development challenge of mental health conditions will require additional funding to bridge resource gaps and address low availability and quality of treatment. Indeed, while 7.4% of the global burden of disease, only 2% of national health budgets is devoted to mental health programs ^[4] However, rather than advocating for another "silo" approach, focused on funding for individual health conditions, multi-sectoral funding must be leveraged to scale up mental health interventions, while also promoting efforts to reduce duplication and inefficiencies as well as stigma and discrimination.

As highlighted at various global health events held at the World Bank Group (WBG) since 2016, it is possible to accomplish this. Governments, in accordance with the Addis Ababa Financing for Development Action Agenda, have the responsibility to mobilize additional domestic resources to help achieve mental health parity, as part of the progressive realization of universal health coverage. One way to do this is to increase tax rates on tobacco, alcohol and sugary drinks, which can not only provide a source of additional revenue, but also help generate public health benefits by reducing the risk of noncommunicable diseases.

Cooperation across sectors also will provide an opportunity for multilateral finance institutions such as the WBG, bilateral agencies and philanthropies to use existing service platforms to support the scaling up of mental health prevention and treatment. For example, to address the critical, but often overlooked, association between maternal depression and childhood stunting, support could be provided as part of integrated maternal and child health interventions under platforms such as the Global Financing Facility in support of Every Woman, Every Child (GFF). Investment in other areas, including education and social protection, could be utilized to respond to the unique needs of youth and other vulnerable groups, using initiatives such as the WBG's Human Capital Project. This is an important consideration as the different dimensions of human capital complement each other, starting at an early age; e.g., proper nutrition and stimulation, in-utero and in early childhood, have shown to improve people's physical and mental well-being, and contribute to development of cognitive and socioemotional skill.

Similarly, integrating mental health into wellness programs in the workplace can help leverage funding from firms and enterprises as a sound investment resulting in significant benefits for workers, their families and employers, improving productivity and competitiveness. Multi-sector programs used for the reintegration of displaced populations and refugees in post-conflict and post-disaster societies, such as those funded under the WBG's IDA and IBRD windows, could help mainstream and scale up mental health interventions and related social services among these vulnerable and at-risk populations. Microcredit schemes, such as Rise Asset Development in Canada, which provides low-interest small business loans, training and mentorship to entrepreneurs with a history of mental health or addiction challenges (including former prisoners), could be supported to facilitate the reintegration of those with mental health conditions back into the community.

Dedicated accounts, such as the International Finance Facility for Immunization (IFFIm), are another example of an innovative approach that could be used to mobilize additional funding to scale up global mental health services. This facility, which was established in 2006 to rapidly accelerate the availability and predictability of financing for immunization programs, uses long-term pledges from donor governments to issue "vaccine bonds" in capital markets, thereby making substantial funding immediately available for these programs.

These various approaches should be explored and utilized, since improving lives by addressing mental health conditions is a moral obligation for all those concerned with sustainable development. As was noted by Canada's Minister of Health, Ginette Petitpas Taylor, during the 2018 WBG-IMF Spring Meetings: "Almost no one in society is left untouched by mental illness. Directly or indirectly, sometimes without even knowing it, mental illness affects nearly everyone at some point in their lives." It is time, therefore, to deliver results, including for our young people.

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Mineral wealth for human development: The Texas way



Submitted by Patricio V. Marquez On Thu, 01/07/2016

co-authors: Melanie Walker



As countries look to domestic resources to help meet the ambitious development agenda laid out in 2015, there is value in looking at international experiences where mineral wealth has become a dedicated revenue stream for financing development efforts, particularly for investing in human capital (via public health or education).

Why the emphasis on mineral wealth? The answer is simple. Many countries with large endowments of valuable natural resources, particularly in sub-Saharan Africa [1], do not fare better in terms of human development outcomes than less well-endowed countries, and in some cases often do worse.

Yet there are good international examples of spending mineral wealth in ways that benefit people, as in copper-mining Chile [2], diamond-rich Botswana [3], and oil-producing Malaysia [4] and Norway [5]. There's also one in the United States [6] – Texas.

We share a deep connection to Texas and would like to highlight this state's century-old experience as another good practice from which we have both benefited. While it is well-known that oil and natural gas contribute to almost half of the economic activity in Texas, not many acknowledge that dedicated revenue from oil and natural gas taxes and royalties have played a critical role in funding public education that reduces poverty not just in Texas but around the world.

As mandated by the Texas constitution, the Foundation School Fund, the primary mechanism for transferring state funds to more than 1,000 school districts, is largely financed by 25% of the state's occupation tax revenues, which include oil and natural gas production taxes. In 2014, the state's education system received over \$1 billion in revenue from these taxes.

The Permanent School Fund, a state education endowment worth \$34.5 billion in 2015 (the second-largest in the United States) that is capitalized with annual oil and natural gas royalties and investments managed by the State Lands Board, supports K-12 public schools. This Fund also helps secure AAA bond ratings for school districts, enabling them to pay lower interest rates. It is estimated that the Permanent School Fund has contributed more than \$23 billion to Texas schools since 1960, with about \$1.7 billion being disbursed over 2014-2015.

The Permanent University Fund ^[7] (PUF) is a public endowment that supports 21 institutions of the University of Texas (UT) and the Texas A&M University systems that provide educational opportunities to close to 200,000 students across the state. PUF was established by the 1876 Constitution of the state of Texas through the appropriation of 2.1 million acres of land in West Texas. Since 1923, when oil began to be drilled on what was once cattle-grazing land, the principal of the PUF ^[8], which cannot be spent, has included proceeds from oil, gas, sulfur, and water royalties on this land, gains on investments in the financial markets, rentals of mineral leases, and the amounts received from the sale of university lands. The income generated by grazing leases on university lands and a portion of the earnings from the endowment are distributed across the two university systems (about \$650 million in 2013 alone); the rest is added back into the principal.

The PUF is managed by the Board of Regents of the UT System, which contracts with a non-profit organization for its day-to-day investment management. It grew from \$11.6 billion in 2010 to over \$21.8 billion in 2015 — one of the largest educational endowments in the United States, with slightly more than Stanford (\$21.6 billion) but a little less than Harvard and Yale.

To prevent political interference in the management of the PUF, specific provisions are included in the state constitution limiting how much money could be withdrawn and prohibiting spending on anything outside academics.

In addition to paying taxes and royalties, the oil and natural gas industry contributes funding for special training programs in local high schools and colleges, particularly focusing on science, technology, engineering, and math. This helps the state educational system meet the demand for a skilled workforce in the Texan energy industry and gives students skills to help them find jobs after graduation.

Overall, the experience in Texas shows the benefits of a strong legal framework, well-developed institutional ^[9] and governance arrangements, sound financial management of mineral endowments, infrastructure development, and political and social commitment to human capital development. Dedicated funding streams from mineral taxes and royalties can help meet both the long-term requirements for economic growth when extractive revenues dwindle, as well as the immediate need to build human capital

as a key contributing factor to diversified growth and social well-being over the medium and longer term. Trade-offs made for short-term benefit rarely provide the necessary investment required to ensure shared prosperity.

Mineral-rich countries would do well in applying lessons from the Texas experience in their local contexts, particularly for mobilizing domestic funding needed to support the education-for-all agenda and the progressive realization of universal health coverage. Learning from what has worked well and not so well across the world is perhaps the path to follow in order to overcome the “poverty of imagination” that prevents the creation of more just and prosperous societies.

As we say in Texas, “Hook ‘Em Horns...”

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Taxing tobacco and the new vision for financing development



Submitted by Patricio V. Marquez On Mon, 04/18/2016

As part of the 2016 [World Bank Group-International Monetary Fund Spring Meetings](#) ^[1] held this past week in Washington, D.C., a fascinating panel discussion, [A New Vision for Financing Development](#) ^[2], took place on Sunday, April 17. Moderated by [Michelle Fleury](#) ^[3], BBC's New York business correspondent, it included World Bank Group President [Jim Yong Kim](#) ^[4], [Bill Gates](#) ^[5], [Justine Greening](#) ^[6] (UK Secretary of State for International Development), [Raghuram Rajan](#) ^[7] (Governor of the Reserve Bank of India), and [Seth Terkper](#) ^[8] (Minister for Finance and Economic Planning of Ghana).



The panel was in consensus about the current challenging economic and social environment facing the world as a whole. That environment includes low rates of economic growth across the world, drastic reductions in the price of commodities that are impacting negatively low-and middle-income countries, rising inequality, frequent natural disasters and pandemics, increased number of displaced populations and refugees due to conflict and violence spilling across national borders and continents, and the ambitious [United Nations 2030 Agenda for Sustainable Development](#) ^[9], which includes a set of 17 [Sustainable Development Goals](#) ^[10] (SDGs). A question

debated in the panel was, Where will the resources be found to address these challenges? This question is critical under the current scenario if countries are to continue to build on the progress achieved over the last decade and maintain previous gains.

Gates noted that new and innovative tools are required alongside the promotion, adoption, and adaptation of good practices to make a difference in dealing with these challenges. Terkper advocated for maintaining official development assistance commitments and adopting flexible risk-sharing financial instruments by multilateral organizations to help countries attract and leverage private investment. The importance of investing in the development of healthy and productive populations as key engines of economic and social development over the medium and longer terms was stressed by Kim, who argued that many governments have to be convinced to invest in "soft sectors" — health, nutrition, and education — compared to the "hard sectors" — roads, ports, and energy infrastructure.

While international financial assistance is necessary to help countries translate into reality the vision for a world free of extreme poverty, where there is opportunity for all, it should be recognized, as observed by Rajan, that domestic resources depend in large measure on economic growth. Growth, in turn, is supported by an enabling economic, social, and environment policy environment, including counter-cyclical fiscal policies, adequate fiscal space, and good governance. But, as highlighted by Greening, national governments must recognize that in accordance with the Financing for Development Addis Ababa Action Agenda ^[11] adopted in July 2015, the active mobilization and effective use of domestic resources, underscored by the principle of national ownership, are central to the common pursuit of sustainable development.

If development is lifting up lives, and new and innovative approaches for funding development are seen as “game changers,” then I would argue that the development community needs to redouble its commitment to advocate with national governments and society at large for raising taxes on tobacco products. Taxing tobacco is one of the most cost-effective measures to reduce consumption of products that kill prematurely, make people ill with all kinds of tobacco-related diseases (e.g., cancer, heart disease, respiratory illnesses), and cost health systems enormous amounts of money for treating often preventable diseases. In addition, hiking tobacco taxes can help expand a country’s tax base to mobilize needed public revenue to fund vital investments and essential public services that benefit the entire population and help build the human capital base of countries, such as financing the progressive realization of universal health coverage ^[12] and mental health scale-up ^[13] as well as education for all and early childhood development ^[14] initiatives. Indeed, data from different countries indicate that the annual tax revenue from excise taxes on tobacco can be substantial (e.g., close to 1% of GDP or \$3 billion in the Philippines ^[15] in 2015).

We at the World Bank, in partnership with the Bill & Melinda Gates Foundation ^[16] and Bloomberg Philanthropies ^[17], as well as World Health Organization ^[18], are already working and committed to support countries in the design and implementation of tobacco taxation policy measures and monitoring their health and fiscal revenue impact, as a critical element of the global development agenda. The time has arrived to make tobacco taxation an important source of domestic resource mobilization that has the potential to generate substantial health and social welfare dividends across the world.

7.

The Way Forward

Time for mental health to come out of the shadows



Klaus Vedfelt/Getty Images

Mental disorders, such as depression, anxiety, and substance use disorders, impose an enormous global disease burden¹ that leads to premature mortality and affects functioning and quality of life. If left untreated, mental disorders can result in worse treatment adherence and outcomes for commonly co-occurring diseases, such as tuberculosis, diabetes, cardiovascular disease, and cancer.² Yet parity between mental and physical health conditions remains a distant ideal. Poor mental health also impacts on economic development through lost production and consumption opportunities at both the individual and societal level.^{3,4} Unfolding tragedies, such as the conflict in Syria, displaced populations in Colombia, the burgeoning refugee crisis in the Middle East and Europe, and reconstruction efforts after natural disasters in Japan and Nepal or disease outbreaks such as Ebola virus in west Africa, compound mental health needs of affected populations. But the mental health aspect of these crises is often overlooked.

To highlight the scale of these issues, and the gains from addressing them, the World Bank Group and WHO co-hosted the Out of the Shadows: Making Mental Health a Global Priority meeting in April, 2016. This event aimed to put the mental health agenda at the centre of global health and development priorities by spurring efforts to: increase awareness about mental health as a development challenge and the associated economic and social costs of inaction; debate the economic and social benefits of investing in mental health; and identify ways for stakeholders to act across sectors.

Jim Yong Kim, President of the World Bank Group, and Margaret Chan, Director-General of WHO, along with other leaders,⁵ called for a collaborative response to tackle mental health as a development challenge by pursuing multidisciplinary approaches that encompass integrated health services at the community level, in schools and in workplace programmes, and initiatives to address the mental health and psychosocial needs of displaced populations. Funding is needed to build upon social protection and employment schemes that facilitate the reintegration of affected persons back into their communities.

New pledges were made and existing commitments to mental health were reaffirmed. The World Bank stated its intention to incorporate mental health

into its programmes and activities across sectors, including health, education, social protection, fragility, emergencies and reconstruction, and conflict and violence. This support included a commitment to champion mental health parity in the provision of health services, as part of its programmes to support the realisation of universal health coverage.⁶

Complementing these commitments, WHO announced its continued commitment to support and monitor implementation of the Mental Health Gap Action Plan (mhGAP),⁷ which aims to scale up mental health services in low-income and middle-income countries. WHO also announced that the next WHO-led World Health Day in April, 2017, will be devoted to depression and suicide.

The business sector committed to working towards a more supportive work environment. A promising initiative is the seven-step guide to workplace mental health, developed by the World Economic Forum's Global Agenda Council on Mental Health.⁸ Another focus was the contribution of business to mental health in the development of new technologies, such as mHealth, that can help improve access to care and reach vulnerable populations.⁶

Researchers committed to generating evidence and pioneering new approaches to address the challenges of mental health prevention, detection, and treatment. The Innovation Fair, co-organised by the Mental Health Innovation Network and funded by the Wellcome Trust with contributions from Grand Challenges Canada and the US National Institute of Mental Health, offered many innovative approaches in mental health that can be used at scale and implemented in low-resource settings, even in the context of fragility and conflict. As a key next step in generating new evidence and advancing research, the Global Alliance for Chronic Diseases announced the launching of a US\$50 million call on research into mental health (including dementia).⁹

The intergovernmental forum Asia Pacific Economic Cooperation (APEC) also committed to prioritise mental health through full implementation of the APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific¹⁰ and the launch and growth of the APEC Digital Hub for Best and Innovative Practices in Mental Health Partnerships.

Non-governmental organisations presented new collaborative initiatives for mental health advocacy

and support. Two new platforms were launched to bring organisations together under the banner of mental health: mhNOW and an NGO call for action #NGOs4mentalhealth. Both call on development partners to support their efforts by integrating mental health into existing programmes and building capacity for mental health, in collaboration with people living with mental health problems and their carers.

The cross-cutting nature of mental health issues, and the need to integrate mental health services into general health systems as part of the progressive realisation of universal health coverage, were consistent themes advocated by policy makers and politicians throughout the event. Alongside the inclusion and scale-up of essential mental health services as part of national health insurance benefit packages, a number of other key entry points for integrating mental health into related programmes were recommended, including maternal and child health programmes, workplace health and wellness programmes, and as part of rescue and reconstruction work in conflict and humanitarian settings.

The economic impact of mental health on individuals and society is a major global challenge for development. The global economy loses about \$1 trillion every year in productivity due to depression and anxiety.¹¹ However, the return on investment for mental health innovations, and specifically the finding that every \$1 invested in treatment for depression and anxiety can lead to a \$4 return in better health, was a key take-home message of the meeting.¹¹ Ministers of Finance reacted to this situation by calling for global action. Canada's Finance Minister William Francis Morneau made a commitment to support mental health across health, corporate, housing, education, and justice sectors, and set an inspiring example for others to follow. Ethiopia's Minister of Health, Kesetebirhan Admasu, promoted the idea of a national mental health trust fund. Alternative sustainable funding models were also put forward, such as Canada's RISE Asset Development, which lends at low interest rates to people with a history of mental health and addiction challenges. There is still a long way to go to promote investment, resources, and accountability in the mental health sector.^{12,13} Next steps include enhanced international cooperation;¹⁴ the creation of private-public partnerships, specifically with technology companies; integration of mental health into other health and development sectors; and exploration of alternate models of mental health

financing, such as the dedicated use of revenue from higher taxes on tobacco and alcohol.¹⁵ Each sector must keep the momentum going, and it is only by increasing collaboration and resources to make mental health a global development priority that progress will be made.

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We declare no competing interests.

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GLOBAL MINISTERIAL MENTAL HEALTH SUMMIT

Tuesday 9 and Wednesday 10 October 2018

County Hall, London, UK

RECOMMENDATIONS: “The economics of, and investment in, mental health workstream session”

RECOMMENDATION 1

Action:	Governments should aim to increase their mental health allocation to at least 5% in low-middle income countries (LMICs) and at least 10% in high-income countries (HICs) of the total health budget to achieve mental health parity by 2030.
Population served:	All
Outcome achieved:	Increased domestic resource mobilization and allocation of funding help bridge current resource gaps and ensure long term sustainability of scaled up effort.

RECOMMENDATION 2

Action:	Investment should be paired with measurement of mental health outcomes. The current efforts such as the World Bank Group’s Human Capital Index and OECD’s Mental Health Performance Benchmarking are potential opportunities that should be supported by government. Scale up of services should be guided by evidence, as exemplified by Canada through Grand Challenges Canada’s investment in mental health.
Population served:	All
Outcome achieved:	Accountability for funds spent to translate to outcomes.

RECOMMENDATION 3

Action:	Donor countries, private sector, and philanthropies should play a critical role in scaling up through new co-financing arrangements with domestic governments to bring mental health to scale. Countries should leverage established multilateral platforms, i.e. World Bank's GFF, Human Capital Project and IDA fund for displaced populations, refugees and host populations; and other funding mechanisms as outlined in Financing Global Mental Health report.
Population served:	Selected low and middle-income countries; vulnerable and marginalized people
Outcome achieved:	Alternative funding sources tapped to scale up global mental health effort.

RECOMMENDATION 4

Action:	Governments should leverage investment across sectors to address mental health across the life-course as a basic human right. Employers, educators, judicial system, and social services, all have roles to play.
Population served:	Selected low and middle-income countries; vulnerable and marginalized people
Outcome achieved:	Cooperation across sectors facilitate funders (multilateral finance institutions, regional development banks, bilateral agencies, and philanthropies), as well as private and public firms and enterprises, use of existing service delivery platforms to support scaling up integrated mental health interventions.

About the Workstream

The **goal** under the workstream “**The Economics of, and Investment in, Mental Health**” centered on reframing the global mental health agenda from a focus on the reduction of the treatment gap for people affected by mental disorders to the improvement of mental health as a critical investment for enhancing health capital, develop human capital, both stock and quality, increase productivity, and contribute to expand the total wealth of nations to achieve inclusive societies.

The main **objective** of the presentations and interactive discussion during the workstream session was to address the following questions:

- **Why invest in mental health (setting out the magnitude of the economic consequences of mental illness, its underlying links to poverty and other socioeconomic determinants, and relevance to UHC, sustainable development and human capital agendas)**
- **What to invest in (covering the economic evidence base, best buys, return on investment and universal versus more selective or targeted interventions and vulnerable groups over the life-course)**

- **How to fund and leverage funding across sectors to scale-up mental health interventions across different service delivery platforms, promoting synergies with other health and development programs; different modalities for raising and spending revenues for integrated mental health system development**

This session presentations, delivered by a well-balanced (gender, geography) group of experts covered different dimensions agreed for the workstream under the coordination of two co-chairs who served as moderators. Then presenters, participants, and co-chairs discussed the presentations and came up with a set of recommendations/consensus statements that were submitted to ministers the following day of the Summit.

The session panel of presenters and co-chairs included:

Co-Chairs/Moderators: Patricio V. Marquez, World Bank Group, and Karlee Silver, Grand Challenges Canada

Presenters/Topic Covered:

- **“Mental Health, Work and Productivity: Evidence from the OECD”: Emily Hewlett, Organization for Economic Co-operation and Development (OECD)**
- **“Best buys, the cost of scale-up and returns to investment in mental health care and prevention”: Dan Chisholm, World Health Organization Office for Europe**
- **“Mental Health Parity under the Affordable Care Act in the United States”: Gilberte Bastien, Ph.D., Associate Director - Office of Global Health Equity, Assistant Professor - Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine Atlanta, Georgia**
- **“Internally Displaced Persons (IDPs): An Integrated Approach to Rehabilitating IDPs with Dignity under Multisectoral Investment Programs”: Toluwalola Kasali, former Adviser to the Minister of Finance of Nigeria**
- **“Can Responsible Investing in International Capital Markets serve a Catalytic Role in Promoting Mental Wellness and Health in Firms and Enterprises Globally?” Bettina Reinboth, Head of Social Issues, Principles for Responsible Investments, UK**
- **“Leveraging the Power of Economic Blocks to strengthen Mental Health and Reduce the Economic Impact of Mental Illness: The APEC Experience in the Asia-Pacific region”: Raymond Lam, Asia-Pacific Economic Cooperation (APEC) (forum for 21 Pacific Rim member economies that promotes free trade throughout the Asia-Pacific region)**
- **“The Origins of Happiness: The Science of Well-Being over the Life Course”: Lord Richard Layard, London School of Economics.**
- **Rapporteur: Takashi Izutsu, University of Tokyo**

