How to Rebuild a Nation: Improving Mental Health in Post-Conflict Countries

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Introduction

Solving mental health dilemmas has become more of a goal in recent years due to dissipating stigmas and improved access to resources. However, much work has to be done, as in some of the places where assistance is needed the most, the quality and sheer quantity of care is abysmal. This is jarringly evident in post-conflict countries, nations that have undergone immense trauma via civil war (often accompanied by genocide and ethnic cleansing). Examples include Rwanda, Bosnia, Cambodia, Afghanistan, Sudan, the Democratic Republic of the Congo, and many more. Through conflict, infrastructure has been destroyed in these nations, economic and social ties obliterated, indirectly leading to an negative effect on health.[1] But the health infrastructure itself is often severely damaged by war, causing a direct negative impact on health. Programs have been put into place by the World Health Organization (WHO) in conjunction with local groups to revitalize nations that have been hurt by conflict; however, mental health has rarely been a priority in that reconstruction process. In areas affected by conflict, one in five people is living with some form of mental disorder, from mild depression or anxiety to psychosis, and 1 in 10 is living with a moderate or severe mental disorder. UN estimates suggest that in 2019, nearly 132 million people in 42 countries around the world need humanitarian assistance resulting from conflict or disaster. Nearly 69 million people worldwide have been forcibly displaced by violence and conflict, the highest number since World War II. [2] All of these individuals need access to adequate mental care, and currently, they do not have it. And it has been shown that untreated posttraumatic stress will only get worse and lead to increased morbidity and lower quality of life. [3] The purpose of this policy brief is threefold: 1) to disseminate information regarding mental health in specific post-conflict contexts, 2) to dictate current policy efforts, and 3) to recommend future directions for instituting proper mental reform throughout these post-conflict nations.

Background

Prevalence of Mental Illness in Various Post-Conflict Countries

Rwanda

In the 1994 Rwandan Genocide, around one million people were killed, 250,000 women were raped, and millions of Rwandans were displaced. 94% of people in Rwanda during the genocide experienced at least one genocide event (i.e. witnessing the murder of family members, having their property and homes destroyed, or having their lives threatened).[4] In 2004, 24.8% of Rwandas met symptom criteria for PTSD. [4] It is important to analyze the role of culture in presenting symptoms of mental illness. For example, avoidance/numbing is a criterion that is critical for the diagnosis of PTSD. 43.2% of those meeting PTSD symptom criteria experienced at least 3 avoidance/numbing symptoms. Rwandan culture discourages open displays of emotion; thus, some of the symptoms may be mediated by cultural expectations. [4] During the genocide, most health workers had either been killed or fled the country, and many who remained had been complicit in the genocide, so trust in physicians and nurses has been frayed. [5]

Former Yugoslav Republics

In 1991, following declarations of independence by several of the Socialist Federal Republic of Yugoslavia's constituent republics, the Yugoslav National Army reacted with harsh violence. After almost five years of conflict, an internally enforced peace accord was implemented. Bosnia-Herzegovina was left with an economy in tatters, at least 100,000 deaths, and roughly half the population internally displaced from their homes or driven into exile. [6] The wars were accompanied by ethnic cleansing, as Serbs committed genocide against Bosnian Muslims and Albanians. Much research has been done regarding refugee populations and their health; however, rarely has the health of those still living in post-conflict countries been looked at. In a study done with Kosovar Albanians, it was found that, in 2001, 89.5% of the population had PTSD symptoms and that a history of PTSD

might not only be associated with medical morbidity but also with increased mortality. [7] This highlights the dire importance of addressing mental health epidemics in these nations, because there is a direct relationship between unaddressed mental health problems and mortality.

Sudan

Over the past few decades, Sudan has gone through an abundance of conflict. In 2005, the signing of the Comprehensive Peace Agreement marked the end of the civil conflict between the Islamist central government and the Sudan People's Liberation Movement/Army that had lasted over 20 years. In 2009, it was found, in Juba, Southern Sudan, that over one third of respondents met symptom criteria for PTSD and half met symptom criteria for depression. [8] The 2005 agreement did not lead to lasting peace, and again, military dictatorship ensued, leading to immense numbers of death and strife. In July 2019, an agreement between Sudan's military and opposition groups marked the end of nearly three decades of military dictatorship. In the aftermath, it has been found that 7-8 million people are in need of medical assistance, facing critical problems related to mental and physical wellbeing. 58% of the population cannot afford a daily food basket and 26% do not have access to safe drinking water. [9] Instituting proper health care infrastructure in Sudan must include addressing resource scarcity and the diminished economic output.

Other Countries

Unfortunately, many more countries suffer from wounds caused by conflict. Much of the research performed has been focused on Rwanda, the Balkans, and Sudan. But in Sri Lanka, from the 1980s until 2009, there had been a struggle between the Tamils and the Sinhalese government. In Indonesia, there has been recurring violence between Muslim and Protestant populations. In Nepal, in 1996, the Communist Party of Nepal announced a "people's war" against the government of Nepal. These are just a few more examples. Since 1946, there have been 140 civil wars with 20 million casualties and 67 million displaced persons. [10]

Current Policy Efforts: Reforming Mental Health Standards

There are a variety of different interventions that are attempting to ameliorate mental health standards throughout conflict-ridden zones. Some countries are adding mental health provisions to their existing healthcare systems. In Rwanda, the health care system consists of two agencies that provide specialized mental health care: CARAES Ndera Neuro-Psychiatric Hospital and the Psychosocial Consultation Service. In 2004, CARAES Ndera created a service branch called Le Centre Psychothérapeutique Icyizere (The Hope Center) whose mission is to serve patients with PTSD. The Center's services included medication management, therapy (individual, group, and family), and detoxification. The health providers are primarily bachelor's degree level psychiatric nurses and psychologists who receive continuing education. Using the PTSD Checklist-Civilian Version (PCLC) as a diagnostic guideline, it was found that PCLC scores at discharge from Icyizere were significantly lower than at intake. Even though Icyizere was designed to promote PTSD care, most adults were diagnosed with psychotic disorders, substance use disorders, or depression. [11] This may be due to lack of community awareness about PTSD, so when individuals are facing symptoms, they do not check themselves in to receive care.

Other types of programs are trying to encourage healthy lifestyles to promote health. In recent years, there has been a growing amount of evidence demonstrating the efficacy of instituting physical activity interventions for people with mental health problems. In sub-Saharan Africa (SSA), where there is a rising and devastating burden of mental and substance use disorders, it was found that not only are these kinds of interventions low-cost but they actually work. In SSA countries, only Namibia and Uganda included physical activity priorities as part of their mental health policy, and there is a direct correlation between the increased rates of exercise and lower prevalence of depression symptoms. [12]

Some mental health policies and programs are

specifically targeting children, who are especially vulnerable to the effects of conflict. In 2004, the Child Thematic Program was started, which included prevention, treatment, and rehabilitation interventions. The program was applied to Burundi, Indonesia, Nepal, Sri Lanka, and Sudan. The initiative included increasing general awareness of mental health, identifying children with elevated psychosocial distress (in a non-stigmatizing manner), and treating children with severe mental health problems. The program was tailored to each locale it was functioning in, and there were positive effects of the culturally specific interventions. The program resulted in improved case detection with a developed and validated screening instrument, making care accessible to over 96,000 children. [13]

While directly building medical infrastructure is essential, many medical professionals have shown it is not enough. After an event like a civil war or a genocide, societal trauma must be addressed and psychosocial healing must be integrated in the treatment. In Former Yugoslavia, the Medical Network for Social Reconstruction was established to facilitate healing processes that promote individual and community health and prevent future conflicts in the Balkans region. The Network operates on two basic principles: 1) violent conflict and war are the ultimate threat to public health and 2) the healthcare community must not only mend the physical and psychological wounds of individuals but also create bridges for community reconstruction and social reconciliation. According to Vamik Volkan, a pioneer in the diagnosis and treatment of societal trauma, a traumatized society can undergo "psychosocial degeneration", where a large fraction of the society loses its sense of trust in their community and the wider world. Societal shame, humiliation, and helplessness may become internalized and complicate an already-present guilt. As a result, maladaptive social patterns develop, such as increased rates of prostitution, domestic violence, and organized crime. [14] Thus, the social constructs of the society must be rebuilt. Storytelling is an important part of this, as when a survivor tells the story of their trauma, it can transform the traumatic memory so the survivor can then integrate the memory into their life story. Another action that works is encouraging volunteerism. Individuals in difficult and traumatic situations frequently derive satisfaction from volunteering to help fellow sufferers. Most post-conflict situations lack resources necessary to provide proper support for children, so volunteer action could have a widespread benefit there. [14] It must be noted that social reconstruction programs are not sustainable unless they actively seek synergy with other sectors, such as water and sanitation, education, and internal security.

Policy Recommendations

1) Interventions must move from a biomedical to a biopsychosocial model.

Currently, with these packages from organizations like the WHO and UN and with intracountry approaches, there is a tendency to overprescribe medication and overdiagnose. It has been proven time and time again that drug interventions are not enough to uplift populations that have undergone immense trauma. Interventions must include therapy, physical activity, and social reconstruction programs. Regaining social capital has been directly linked to positive health outcomes. [17] In the study of Kosovar Albanians, it was found that when biological approaches to PTSD treatment are not associated with relational (psychotherapeutic) treatment, the impact is severely limited. [7] Thus, policies enacted throughout post-conflict countries must be based on an interdisciplinary approach, ensuring the context in which the individual is healing is healthy.

2) The interventions must be culturally specific.

The biggest complaint about WHO guidelines on how to rebuild infrastructure in a post-conflict setting is that the recommendations are too general and this "one-size-fits-all" approach does not work. In Syria, art therapy workshops and theater productions like "Antigone of Syria" have been helpful in restoring social cohesion. [15] In Afghanistan, a technique called "focusing" has been used to alleviate the psychological distress of Afghan aid workers. "Focusing" is similar to meditation,

which is beneficial, because in Afghanistan, it may be shameful to openly discuss problems. [16] Culturally specific interventions have also worked in Lebanon and Gaza.

3) Organizations like WHO and UN must empower local structures.
The interventions must remain effective after these international organizations leave. Thus, local professionals must be taught appropriate psychotherapeutic techniques and must be given the tools they need to help their people themselves, ensuring they are not dependent on any external individual or organization. WHO and UN interventions must prioritize self-sufficiency.

Additional Resources

- **UN Brief on Post-Conflict Countries**: https://www.un.org/en/development/desa/policy/wess/wess_bg_papers/bp_wess2008_panic.pdf
- **mhGAP Humanitarian Intervention Guide (mhGAP-HIG)**: Clinical Management of Mental, Neurological, and Substance Use Conditions in Humanitarian Emergencies: https://www.who.int/mental_health/publications/mhgap_hig/en/
- **WHO reports on global mental health**: https://www.who.int/data/gho/data/themes/mental-health
- **Partners in Health** (Support Global Mental Health: pih.org/programs/mental-health
- **International Medical Corps**: https://internationalmedicalcorps.org/

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