Mental Health in Foreign Aid

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This paper reviews the impact and possibility of mental health resources in foreign aid. While foreign aid often defines "health" as purely physical health, this paper explores— and advocates for— the incorporation of mental health into that concept of health. First, this paper outlines the state of mental health in developing countries. Then, this paper highlights the insufficient psychological resources and treatment currently available in developing countries. After detailing the insufficient resources, this paper highlights certain case studies for mental health interventions in developing countries like the Democratic Republic of Congo, China, and Colombia. Finally, current initiatives in foreign aid focused on mental health are outlined. This paper concludes that there is a pressing need for mental health interventions in developing countries.

Background and literature review

In the context of foreign aid, "health" is typically defined as physical health. Foreign aid focuses on improving physical health outcomes in developing countries by, for instance, providing bed nets to prevent malaria, helping people grow food sustainably so they don't go hungry, or vaccinating people against deadly diseases. Mental health is rarely addressed or discussed in these frameworks, perhaps due to the global stigma around mental health issues or the ostensibly greater urgency to rectify physical health issues. Although poor physical health is often rampant in developing countries, impaired mental health is similarly common given the interrelated relationship between the two (Elliott 2016). Moreover, although mental illness is stigmatized throughout the entire world, its treatment in developing countries is shockingly insufficient at best, flagrantly abusive at worst. According to the World Health Organization, or WHO, 78% of global suicides occur in low and middle-income countries (WHO 2017). Ameliorating mental health in developing countries would engender more improvements in physical health, leading to better and more cost-effective outcomes in foreign aid. However, although it has gained more attention in recent years, the role of mental health in foreign aid remains negligible. In this paper, I argue that a greater focus on mental health interventions in foreign aid is imperative, as demonstrated by need and past successes. I first explain historical and current discourse about the state of mental healthcare in developing countries, and the portion of foreign aid dedicated to mental health issues, based on existing literature. Next, I analyze past successes of mental health interventions in developing countries, using both quantitative and qualitative data, and current mental health initiatives. I then discuss a potential counterargument to my thesis: the debate over whether the usage of Western mental health treatment methods in developing countries is appropriate, or ineffec-

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tive. I conclude by reiterating my call for more foreign aid policies focused on mental health and clarifying the importance of implementing them with cultural sensitivity.

State of mental health in developing countries

The relationship between mental health issues and poverty is direct and strong, which has devastating implications for the state of mental health in developing countries. For those living in poverty, mental health issues are more severe, last longer, and have worse consequences (Lund et al. 2010). Mental disorders are also more prevalent in people who are unemployed, living in overcrowded housing, experiencing hunger, or suffering financial difficulties (WHO 2017). Moreover, living amidst violence or conflict increases the chance one has of developing a mental disorder such as depression, anxiety, psychosis, or post-traumatic stress disorder (Marquez 2016). A study by Ferrari et al. found that the Middle East and North Africa, which encompass several areas of high poverty and conflict, have the highest depression rates in the world. The country with the highest level of depression in the world is Afghanistan, where more than one in five people have the disorder. Notably, the rates of depression might be even higher than reported in these regions, as their countries often have poor public health services and may consequently diagnose people at lower rates than are accurate (Ferrari et al. 2013). People in post-conflict areas also tend to have unusually high levels of PTSD; McMullen et al. found that four years after the war in Uganda ended, 57% of adolescents still demonstrated clinically significant symptoms of PTSD (McMullen et al. 2011). Similarly, Familiar et al. found that 44% of citizens suffered psychological distress during the Burundi conflict, and 29% of citizens were still experiencing psychological distress two years after the conflict (Familiar et al. 2015).

Poor mental health and poverty can also exacerbate one another through a cyclical relationship; if people do not have the resources to seek treatment for their mental disorder, their mental condition will likely deteriorate and preclude them from improving their socioeconomic standing. This cyclical and perpetuating relationship is present across multiple generations. If a child is born into poverty, their health is likely to be compromised by the poor nutrition of their mother, as well as her subpar working conditions and exposure to stress. This cumulative exposure to stressors at a young age can disrupt neurological development and brain functioning, which increases risks in adolescents for mental disorders like depression and substance abuse (Elliot 2016).

Insufficient psychological resources and treatment in developing countries

Despite the prevalence of mental health issues in developing countries, the psychological resources and treatment to which people suffering from mental disorders have access are often negligible and can even be harmful. Ngui et al. found that in many developing countries, there is no budget for mental health services (Ngui et al. 2010). In Ghana, the treatment gap of people who have a mental health issue but have not received treatment is 98% (WHO 2017). In Mozambique, there are 0.04 psychiatrists per 100,000 people, which is 30 times less than the global median of psychiatrists

in countries and 150 times less than the median in developed countries (Sweetland et al. 2014). In Ethiopia, a country of 77 million people, there are only 18 psychiatrists, who all work at the same hospital that is located in the capital city (Alem et al. 2008). On a larger scale, international spending for mental health in low- and middle-income countries remains starkly low in comparison to high-income countries. In its 2014 Mental Health Atlas, the WHO found that low-income countries spend $1.53 per capita on mental healthcare annually and middle-income countries spend $1.96, whereas high-income countries spend $58.73 (WHO 2014). In low- and middle-income countries, the majority of expenditures go towards mental hospitals, whereas in high-income countries, the spending is approximately equally distributed among mental hospitals, other inpatient and day care, and outpatient and primary care (WHO 2014).

Reasons for this disparity range from the stigma and lack of awareness around mental health disorders, to basic insufficiencies in the research capacity of a country, to limited material and human resources. Moreover, as Sweetland et al. argue, implementing mental health care and policies requires a sizable workforce that can "assess local needs, adapt and test interventions, and identify implementation strategies" that will bring evidence-based practices to fruition (Sweetland et al. 2014); many developing countries do not have this sizable workforce, and if they do, people are likely focused on immediately rectifying physical health needs such as inaccessibility to clean drinking water or insufficient nutrition.

In some developing countries, poor mental healthcare transcends inadequate resources and results in massive violations of human rights, largely due to a pervasive belief that mental health disorders result from the possession of evil spirits (Gallagher 2016). For instance, common practices by local healers to treat mentally ill people in Aceh, Indonesia include chanting, poking patients with burning sticks, and whipping them to eradicate evil spirits that they believe cause mental illness. If these methods fail, healers resort to what they call "pasung," which refers to confinement; they restrain patients with chains and place them in cells (Miller 2012). One woman in Ghana who suffers from schizophrenia tells a harrowing tale of how, before she received treatment from a healthcare non-profit, she was constrained with a wooden shackle over her ankle, confined to a single room, sprinkled with herbal powders, and painted with pale dye to purge her body of demons possessing her (Carey 2015). In Senegal, some methods to expel depression from the body are even more barbaric: the sufferer has to lay in a wedding bed with a ram as the village dances around the pair, drumming and draping them with cloth. The ram is then slaughtered, alongside two chickens, and the blood of the animals is poured over the naked body of the patient. Finally, the patient is cleansed by village women spitting water on their body (Leach 2015). Although these practices— nearly impossible for those from a developed country to imagine— stem from a basic misunderstanding of mental health mechanisms, they can be quite dangerous in exacerbating preexisting mental disorders due to their isolating and violent natures.

History and current role of mental health in foreign aid

One of the first occurrences that instigated discussion about the role of mental health in foreign aid was a landmark report by the WHO in 2001 titled, "Mental Health: New Understanding, New Hope." The report emphasized the fact that mental health—"neglected for too long," as the report said— is essential for the well-being and success of individuals and countries. The report called for an end to the stigma and discrimination that often accompany mental illness and advocated for the implementation of policies that bolstered prevention and treatment. The report called itself a "landmark publication," for its desire to "raise public and professional awareness" of the burden that mental disorders engender in terms of human, social, and economic costs (WHO 2001).

Ostensibly, the next international publication that shed light on the issue was a series of six papers by Prince et al. in *The Lancet* in 2007, titled "Global Mental Health." Papers ranged in topic from the importance of considering mental health as equal to physical health in "No Health Without Mental Health" to potential obstacles for implementing mental health interventions in "Barriers to Improvement of Mental Services in Low-Income and Middle-Income Countries." As described in its executive summary, the report sought to illuminate the shortcomings in mental health services throughout the world and "formulate a clear call to action." The summary explained that despite their "hidden" nature, mental health disorders "represent…a substantial portion of the world's disease burden" and are often ignored, particularly where resources lack in low- and middle-income countries (Prince et al. 2007). Since 2007, several more initiatives to incorporate mental health into foreign aid have emerged, which I will describe in the second portion of my paper; whether they are direct results of the series by *The Lancet* is not certain, but by shedding light on a largely ignored issue, it was undoubtedly an influential publication.

A study by Gilbert et al. found that development assistance for mental health (DAMH) has increased since 2007, rising from accounting for 0.41% of development assistance for health in 2007 to 0.77% in 2013. Although the growth has fluctuated, it has generally followed an upward trajectory. Interestingly, as seen in Figure 1, the proportion of DAMH given by bilateral donors doubled from 2007 to 2013, with moderate increases each year, whereas that given by multilateral organizations was 15 times greater in 2013 than in 2007, with drastic increases each year. Moreover, while the DAMH provided by multilateral donors was previously dwarfed by that of bilateral donors, it surpassed the DAMH of bilateral donors in 2013. This suggests that the attention multilateral donors are giving mental health is increasing considerably, whereas the focus by bilateral donors—although initially higher— is growing at a slower pace (Gilbert al. 2015).

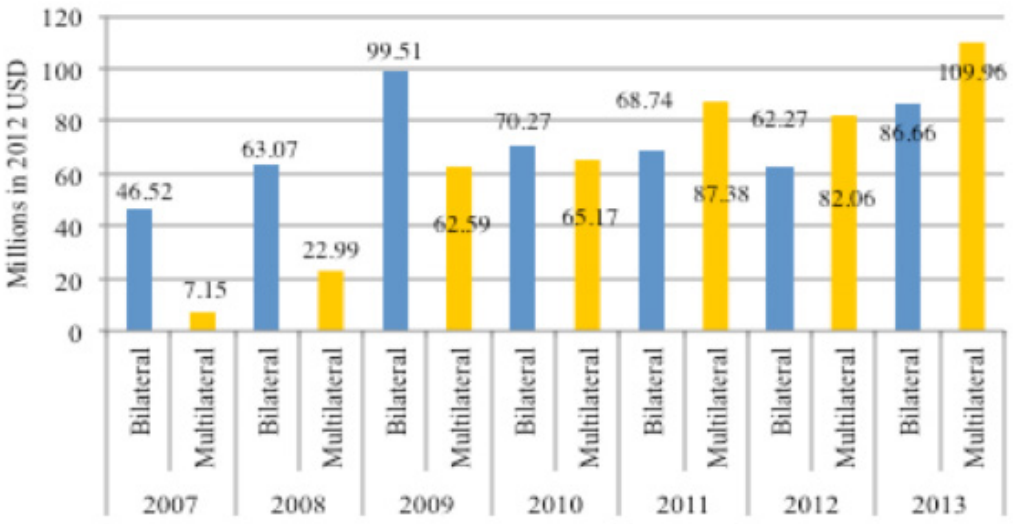

FIGURE 1: DAMH GIVEN BY BILATERAL AND MULTILATERAL DONORS, 2007–2013 (GILBERT ET AL. 2015).

Between 2007 and 2013, the WHO was the most generous donor to DAMH, followed by the European Union institutions, United States, Norway, and Germany, as seen in Figure 2. Gilbert et al. specify that the data might be slightly skewed, as there was a dearth of information available for private nongovernmental organizations. However, the high spending by the WHO was likely spurred by its 2001 report calling for more focus on mental health in foreign aid (Gilbert et al. 2015).

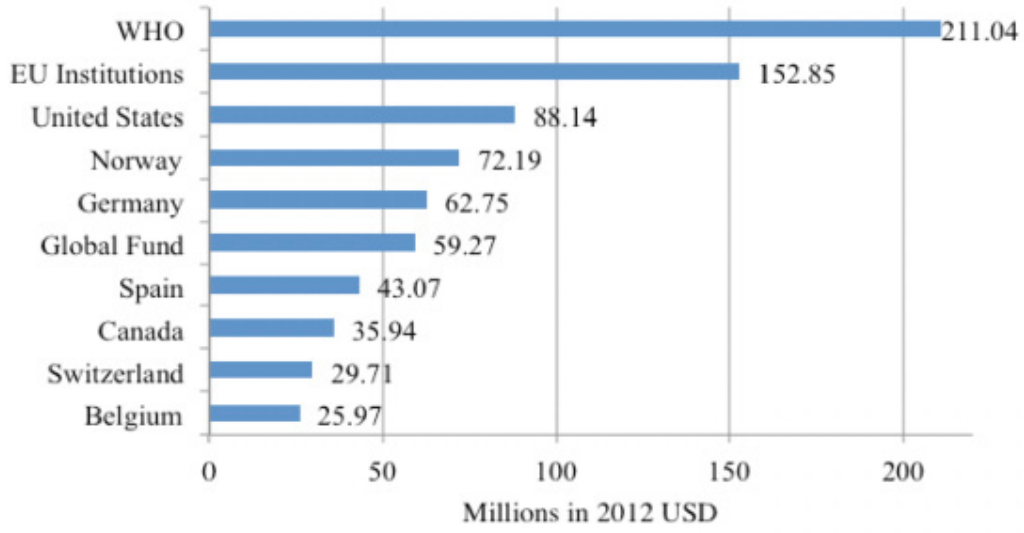

FIGURE 2: MOST GENEROUS DONORS OF DAMH FROM 2007–2013 (GILBERT ET AL. 2015).

The five countries that received the most cumulative DAMH were all involved in conflict or war during the six-year period: The West Bank and Gaza Strip received the most by far, followed by Senegal, the Democratic Republic of Congo, Afghanistan, and Sri Lanka (Gilbert al. 2015).

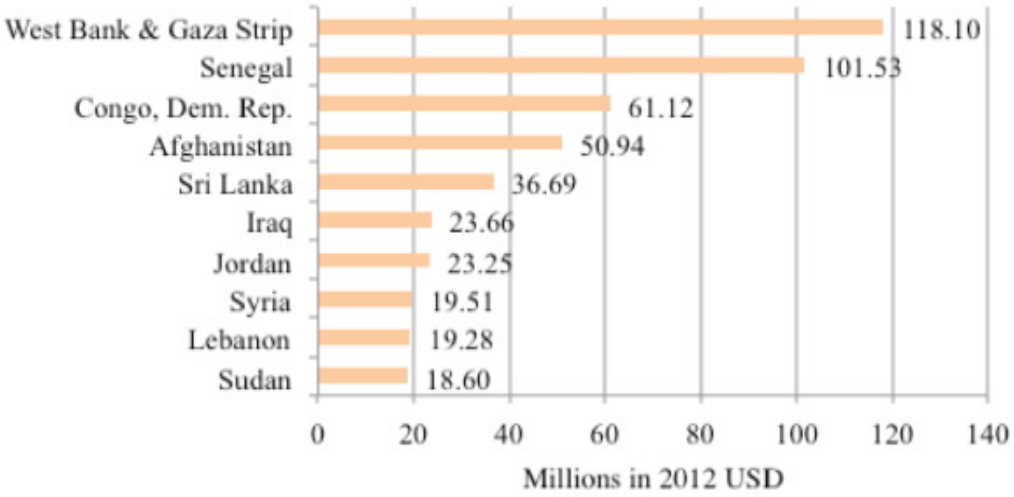

Figure 3: Recipients of the most DAMH from 2007-2013 (Gilbert et al. 2015).

The majority of DAMH funding goes to the health sector, followed by the humanitarian sector, government and civil services, and education. From 2007 to 2013, the amount of DAMH given to the education and government and civil service sectors has remained fairly constant, while that given to the humanitarian aid sector and particularly the health sector has increased substantially. This suggests that mental health is starting to be considered an integral part of health, and is particularly imperative after a crisis or conflict, when humanitarian aid is delivered.

Although donor countries are paying more attention to mental health, DAMH still remains extremely low—less than 1%—as a proportion of overall development assistance to health (Gilbert et al. 2015). Besides the stigma of mental illness and the larger focus on more urgent physical needs another reason for this low proportion is the market-driven nature of aid. In his article in *The Guardian*, "Mental Illness and the Developing World," Andrew Chambers suggests that one reason for the "appalling lack of interest from governments and NGOs" in mental health is that the allocation of funds for an aid project is "strongly correlated with the project's marketability to the public." In terms of donations to charities or organizations, Chambers says, people are more likely to give money when they empathize with an individual in a picture; because people suffering from mental health issues do not necessarily appear any different than those who are not, they cannot create a "good" and heartbreaking "snapshot" that a charitable or non-governmental organization can use to elicit funds (Chambers 2010).

Now that I have provided general background on the poor state of mental health in developing countries, and the inadequate attention it receives in the context of foreign aid, I will explain the successes of specific mental health interventions in developing countries, and other current initiatives focused on the issue.

Mental health interventions in developing countries

Although I have established that providing more mental health care in developing countries is essential, the question then becomes, *how*? Have interventions

thus far been successful? Through the following examples of case studies in the Democratic Republic of Congo, Iraq, China, Colombia, Gaza, West Bank, and India, I will argue that previous mental health interventions have been productive and positive.

Victims of sexual violence in the Democratic Republic of Congo

The International Rescue Committee for victims of sexual violence in the Democratic Republic of Congo successfully spearheaded a mental health intervention after its civil war, outlined by Bass et al. With its two decades of Civil War, Congo has been labeled the rape capital of the world by the U.N. but has little to no mental health resources for the victims of this trauma (Grady 2013). In 2010, Peterman et al. found that nearly two million Congolese women have been raped in their lifetime, spanning from the age of young children to grandmothers; according to their findings, Congolese women are victimized nearly every minute (Peterman et al. 2010). The sexual violence is often of a barbaric nature, involving gang rapes and penetration with knives or guns (Grady 2013). Such traumatizing attacks have devastating consequences on the victims' mental health and well-being.

The IRC, which collaborated with researchers from Johns Hopkins University and the University of Washington in Seattle on the initiative, used cognitive processing therapy or individual support to treat the women. They assigned the interventions in 16 cities, randomly selected, to women who had experienced sexual violence and demonstrated symptoms of PTSD, depression, and anxiety. The group therapy—conducted by local health workers who had been trained by the IRC—entailed 11 two-hour weekly sessions and urged the victims to question why they blamed themselves for the rape, common behavior for people who have experienced sexual violence. The individual support recipients were able to ask for personal counseling, as well as referrals for economic, medical, or legal support. During mid-2011, a time of ongoing conflict in Congo, the women were assessed three times on their symptoms of PTSD, depression, and anxiety: before the study, immediately after and six months later (Bass et al. 2013).

The improvements in the mental health of the women were great, particularly for the group therapy participants. Of the 70% of group therapy participants who had anxiety or depression before the intervention, only 10% showed symptoms immediately after, and six months later, only 9% did. Of the 60% of group therapy participants who had PTSD before the intervention, only 9% showed symptoms immediately after, and six months later, only 8% did. The results for the individual support were less dramatic, but still positive; of the 83% of individual support participants who had anxiety or depression before the intervention, 53% showed symptoms immediately after, and six months later, only 42% did. Of the 83% of individual support participants who had PTSD before the intervention, 54% showed symptoms immediately after, and six months later, only 42% did. A social worker from Johns Hopkins who supervised the intervention said that anecdotally, barring the statistical improvements, women demonstrated improvements before the study was even complete in areas such as personal hygiene and self-esteem. According to the social workers, the women had

only one complaint: why had they not received this treatment sooner? (Grady 2013).

Based on the results, group therapy—a relatively low-cost intervention—vastly improved the mental health of victims of sexual violence. If this intervention were implemented on a wider scale, it would significantly mitigate the devastating mental health consequences of the rape epidemic in Congo for hundreds of thousands of women, and likely those in other parts of the world.

Brief interventions in China, Colombia, Gaza, and West Bank

Médecins Sans Frontières—also known as Doctors Without Borders—saw similar success in its brief mental health interventions, using principles of Psychological First Aid in post-disaster or conflict-ridden areas: China, Colombia, Gaza, and West Bank. Coldiron et al., who described the interventions, noted that MSF accounted for varying social and cultural contexts when implementing interventions by using local therapists (Coldiron et al. 2013).

In May 2008, the Sichuan province in China was struck by a massive hurricane that killed 100,000 people and displaced five million. From November 2008 to August 2009, MSF offered psychological assistance in sites of temporary housing near the epicenter of the earthquake. Patients were either directed to MSF by healthcare providers or flagged by community screenings and referred to MSF-managed psychological care centers, where they were treated by psychologists and trained volunteer counselors. The majority of patients were diagnosed with anxiety disorders, such as PTSD. Only 14% of patients were assessed as moderately, markedly, or severely mentally ill after the intervention compared to 58% before (Coldiron et al. 2013).

Similar interventions have achieved success in Columbia, which has been ravaged by internal armed conflict for the past 40 years. MSF has provided mental health care in the conflict-ridden Department of Tolima, where citizens have experienced kidnappings, displacements, extortion, and repetitive armed violence. After assessing vulnerable populations, MSF administered either individual or group psychotherapeutic interventions to those who demonstrated clinical depression, anxiety, or PTSD. According to data from February 2005 to February 2008, 76% of patients were identified as moderately or severely mentally ill before the interventions; at its conclusion, 91% of patients showed symptomatic improvement, despite the brief nature of the intervention (Coldiron et al. 2013).

Interventions by MSF in Gaza, which has been rife with armed conflict and political tension for the previous decade, have been similarly effective. Frequent rockets and mortars have harmed the infrastructure of the country, as well as engendered violent injury and death. The intervention was implemented from January 2007 to July 2011. After identifying mental health issues in affected populations, MSF provided either individual or group psychotherapeutic intervention. Most patients had anxiety disorders, with over half suffering from PTSD, and more than half were children under 15. At first contact, 90.5% of patients demonstrated moderate to severe mental health issues. After the intervention, 88.8% had improved symptoms (Coldiron et al. 2013).

Lastly, a similar intervention spearheaded by MSF in the West Bank city of Nablus showed improvements statistically similar to those in Gaza. Like Gaza, West Bank has also been a site of violence and political unrest in the past decade. After assessing mental health issues among the population, MSF provided either individual or group psychotherapeutic intervention.

Among screened patients, anxiety disorders and depression were the most common diagnoses, although PTSD was less common than it had been in Gaza. According to data from January 2007 to December 2011, 88.4% of participants demonstrated moderate to severe symptoms of mental health disorders. After the intervention, 87.9% had improved symptoms (Coldiron et al. 2013).

These four case studies have positive implications for the implementation of brief but effective mental health care across a range of world regions and issues. Coldiron et al. specified that although they did not assess the cost of their interventions, due to the "rapid improvement" they engendered, they would likely be "comparatively small" relative to, presumably, other mental health care programs.

Although areas where ongoing conflict or humanitarian crises are triggering widespread mental health problems might merit the most immediate mental health care, interventions are needed in non-conflict areas as well, as demonstrated by the following intervention in India.

Schizophrenic patients in India

In India, a community-based intervention funded by Wellcome Trust for schizophrenic patients elicited considerable improvements, outlined by Chatterjee et al. According to a study by Loganathan and Murthy in 2011, three out of every 1,000 people in India—which has a population of 1.1 billion people— suffer from schizophrenia. Accordingly, an estimated 3,300,000 people suffer from schizophrenia in the country. Barriers to mental healthcare in India, as well as societal stigmatization of the disorder, are rife (Loganathan and Murthy 2011).

The study by Chatterjee et al., which took place from January 2009 to December 2010, was conducted on people who had been diagnosed with moderate to severe schizophrenia, as well as their caregivers, from three different areas in India. Participants either received collaborative community-based care along with facility-based care, or only facility-based care. The community-based care involved individual treatment plans for patients, structured clinical reviews of their progress by the treating team, psychoeducational information for the patients and their caregivers, and networks with community agencies to help promote social inclusion, provide employment opportunities, and increase access to legal benefits. The facility-based care represented the typical mental health care provided for schizophrenic patients in India, although it is important to note that not all people suffering from schizophrenia have access to this treatment (Chatterjee et al. 2014).

Outcomes, assessed at baseline and at 12 months, were measured by the Indian disability evaluation and assessment scale (IDEAS), which evaluates

disability through examining interpersonal activities, self-care, and communication, and the positive and negative syndrome scale (PANSS), which assesses general psychopathology—schizophrenia in this study (Chatterjee et al. 2014).

Although all participants saw improvements in their symptoms and disability outcomes, as demonstrated by their IDEAS and PANSS scores, those in the combined community-based care and facility-based care (the intervention group), showed more progress than those participating in the facility-based care only (the control group). Of intervention participants, 48% showed a 20% or greater improvement on their IDEAS score, compared to 35% of control participants, at 12 months. Although PANSS scores were on average lower for participants in the intervention group than those in the control group, the percentage of intervention participants who demonstrated a 20% or greater improvement on their PANSS score was 51% for both groups. However, it is important to note that Chatterjee et al. also found that intervention participants were significantly more like likely to report adherence to prescribed medication all or most of the time than the control group. Moreover, as Chatterjee et al. discuss, clinical improvement in severely schizophrenic patients is a gradual process, and a later follow-up with participants might have shown more improvements (Chatterjee et al. 2014).

Chatterjee et al. analyzed the cost effectiveness of the intervention versus the control, and found that the intervention was more expensive, costing $500 more per participant on average over the course of the study. However, one third of these costs went to supervision, which Chatterjee et al. explained is increasingly seen as a fundamental "cornerstone" for the long-term effectiveness of mental health interventions (Chatterjee et al. 2014). Moreover, schizophrenia is arguably the most disabling of all mental disorders (Chaudhury, Deka and Chetia 2006); inevitably, it will require expensive treatment, and is also worth the cost. Although not dramatic, the results of this study suggest that collaborative community-based health care is more effective than the status quo of mental healthcare for schizophrenic patients in India.

Current initiatives focused on mental health

There are a number of current, ongoing initiatives for mental health interventions, some of which are specific responses to humanitarian emergencies and others that have a broader scope, like the case study in India. For instance, the WHO has joined forces with the Ministry of Health in New Zealand to provide psychological support through the Mental Health and Psychological Support Project to victims of the 2015 earthquake in Nepal, after which mental health needs increased substantially. According to USAID, 10% of Nepalese populations affected by the earthquake had suicidal idea. Project activities include reviewing current mental health services in Nepal and building upon them, providing mental health management training to District Public Health Officers, and developing a system to identify mental health problems in children (USAID 2017).

In another initiative, the non-profit Grand Challenges Canada—funded by the Canadian government—has a Mental Global Health program through

which it seeks to "improve treatments and expand access to care for mental disorders" through interventions that are "transformational, affordable, and cost-effective," as well as sustainable. It promotes community-based care —proven to be effective, as demonstrated by the case studies outlined—and also improves access to care for children, develops treatment for use by non-specialists, and increases the supply of medication. According to its goals and estimates, the program could potentially save up to 1 million lives and improve up to 28 million by 2030 (GCC 2017).

Perhaps the largest existing initiative is the Mental Health Gap Action Programme, led by the WHO and started in 2013, which aims to increase treatment services for all mental health-related disorders across low- and middle-income countries. The program states that if its plan is implemented, it will treat tens of millions of people suffering from schizophrenia, depression, and epilepsy and help them lead "normal lives." Current initiatives include supporting survivors of Ebola in Guinea, increasing mental health services in response to Typhoon Hayan in the Phillippines, and reducing suicide rates in Guyana (WHO 2013).

These initiatives show promise but are limited in number. Moreover, the vast majority are spearheaded by non-governmental organizations. As evidenced by the several case studies I outlined, mental health interventions—even brief, moderate ones—can engender marked improvements. Although they are important in any developing country where people do not have adequate access to mental healthcare resources, interventions are especially imperative in conflict or disaster-ridden areas, where mental health is most compromised on a large scale. In the next section, I will briefly discuss potential barriers to implementing such interventions, specifically those involving cultural differences.

Incorporating Western interventions into developing countries

Although given the evidence I outlined, most people would agree that mental health deserves more attention and funding from a foreign aid perspective, some would argue against the current model, which incorporates Western models of mental health care into developing countries. These Western models, some would claim, might not be compatible with developing countries that might be very different culturally.

Anna Leach discusses the issue in her article "Exporting Trauma: Can the Talking Cure Do More Harm Than Good?" She explores whether the traditional Western model of mental health care —"the talking cure"—can be adapted to other cultures. She describes the anecdotal experience of Andrew Solomon, a psychologist writing a book about depression across cultures, in Rwanda: women he was interviewing told him that the disconnect between Western and traditional models of mental health care had been problematic in the aftermath of the Rwandan genocide. In Rwanda, traditional practices for treating mental illness are similar to the ceremony with the slaughter of the ram in Senegal described above. Solomon said that Westerners coming in after the genocide, despite good intentions, could not fathom what the genocide had been like and that their paternalistic attempts to "reframe everything"

fell somewhere between "offensive and ludicrous." The Rwandan people told him they felt re-traumatized by having to retell their stories— they were brought into dingy rooms for an hour and asked to relive their most traumatic experiences. They ultimately asked the Western workers to leave. As IMC mental health adviser Inka Weissbecker puts it, it is a "foreign concept" to many in developing countries to sit down with a stranger and tell them your most "intimate problems." For instance, author Ethan Watters, who wrote a book on the globalization of the psyche, explained that among people suffering from PTSD, in the Western world it is typical that the patient would take time away from their responsibilities to recover; in somewhere like Sri Lanka, Watters says, this would be counterintuitive because people feel the deepest sense of themselves in their social group, and isolation from this group would prevent this positive emotion (Leach 2015). Watters also used the analogy of September 11th, 2001 in the U.S.: how would Americans have reacted, Watters asks, if healers from Mozambique had knocked on doors of family members of the deceased and said they needed to take part in a traditional ritual to sever their ties with the dead? Such actions would have been met with significant backlash, confusion and even anger (Leach 2015).

In their book *Public Health in the Arab World*, Samer Jabbour and Rouham Yamout express a similar sentiment, arguing that there needs to be an alternative mental health framework in the Arab world to Western aid and health workers rushing in to provide mental health interventions "based on Western models and diagnoses." This alternative framework should "avoid pathologizing suffering and medicalization," Jabbour and Yamount argue, suggesting that Western mental healthcare models do both (Jabbour and Yamount 2012). International relations academic Vanessa Pupavac, who does research on the war in the former Yugoslavia, called for an end to focusing on mental health in foreign aid altogether. She said that in the former Yugoslavia, "trauma" has "displaced hunger" and that "blanket-defining" an entire population as traumatized prevents people from recovering (Pupavac 2001). Although her viewpoint has faced disagreement, the notion of leaving people in developing countries to solve their own problems has been supported by others (Easterly 2006). In response to such stances, Weissbacker points to the human rights violations that can arise from traditional mental health care practices, as previously explained. Weissbacker said that in order to bridge the gap between Western expertise and local cultures and experiences, aid agencies should employ anthropologists, who have more nuanced understandings of cultural differences than health workers or psychologists. She noted that MSFhas employed anthropologists for years. Weissbacker notes that it is imperative that locals be consulted when implementing any mental health aid projects in order to be culturally sensitive (Leach 2015).

Past evidence supports this methodology. A study by Guajardo et al. found that consulting experts before providing mental health care interventions to refugees from Iraq in Australia helped develop culturally-sensitive and appropriate approaches. These experts were held to a high standard—they had to be a qualified mental health worker, such as a social worker or psychiatrist, and have worked in refugee health for at least

four years *and* have experience working with Iraqi refugees. The categories Guajardo et al. found to be important in the interventions—which could be generalizable to implementing any culturally appropriate mental health interventions— were cultural awareness, cross-cultural communication, the stigma associated with mental health problems in specific communities, and barriers to seeking professional help (Guarjardo et al. 2016).

A study by Kopinak also found that Western mental health models cannot stand alone when being implemented in developing countries. She found that in Uganda, Western health care interventions are often devoid of preventative measures, emanate from a completely different cultural base than those in developing countries, and are dominated by such conflicting opinions and treatments that it is "difficult, if not impossible," Kopinak says, to implement programs in developing countries based on this model that are both "effective" and "sustainable." Accounting for "distinctive cultures, values, gender, and social issues" across Uganda—and, ostensibly, other developing countries — when implementing mental health interventions is crucial, she argues (Kopinak 2015).

Although the interventions I previously mentioned were primarily dominated by Western models of mental health care—individual or group therapy discussions—the majority, particularly those led by MSF, incorporated local expertise in their interventions. It is imperative that before implementing any mental health intervention, a diverse range of experts—psychologists, local experts, anthropologists— are consulted on the best way to improve mental health and achieve results in a specific context.

Conclusion

The need for mental health interventions in developing countries is great. Although there has been an increasing focus on the issue in recent years, the portion of foreign aid dedicated to mental health remains insufficient. According to estimates by the WHO, depression will be the leading cause of global disease burden by 2030 (WHO 2011). Due to a lack of resources, societal stigmatization around mental health disorders, and lingering misunderstandings about its mechanisms and treatment, mental health care remains particularly poor in developing countries. This holds especially true in places ravaged by conflict or natural disasters, as such incidents often precipitate massive mental health crises. Moreover, some traditional treatments for mental health issues can violate basic human rights. Developed countries, particularly those deliver aid, have an ethical obligation to address mental health issues in developing countries.

The success of past interventions has promising implications for the viability of foreign aid, even if some of the programs were brief. Although cost-effectiveness analyses were not done for most of the interventions, according to the WHO, treatment of depression and anxiety are inexpensive; the average annual cost of treating depression over 15 years is $0.08 per person in low-income countries and $0.34 in middle-income countries. For treating anxiety disorders, the cost is nearly half of the depression treatment rates per person. This results in a benefit-to-cost ratio of 2.3 to 2.6 for depression, and a ratio of 2.7 to 3.0 for anxiety

(Marquez 2016). Besides demonstrating promising numerical improvements, these interventions can engender unquantifiable long-term improvements in quality of life.

Although the need for mental health interventions has been established, the optimal way to deliver them has elicited controversy, particularly over Western models of mental health diagnosis and treatment. This is a debate that transcends the role of mental health in foreign aid, and extends to foreign aid and development assistance more generally: is it permissible for developed countries to impose their own models and beliefs on developing countries? Ultimately, the solution lies in striking a balance. The majority of interventions I outlined incorporated Western models of mental health diagnosis and treatment, but many also utilized local expertise when implementing programs.

Although Western models of health are imperfect and may need to be modified heavily before being implemented on a country-by-country basis, in some cases it is crucial for awareness of Western science to be spread. Particularly in countries like Senegal, which have antiquated and even dangerous beliefs that mental health disorders arise from possession of the mind by evil spirits, people need to be educated that mental health disorders result from chemical imbalances in the brain. Optimal delivery utilizes both expertise and local experts to ensure effectiveness and cultural sensitivity.

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