BMUN LXXII

WORLD HEALTH ORGANIZATION (WHO)

LXXII
SEVENTY-SECOND SESSION

LETTER FROM THE CHAIR

Hello and welcome to BMUN 72!

I'm Niveditha Sukesh! I will be your Head Chair for this year's WHO Committee. I'm a sophomore at UC Berkeley, majoring in Molecular and Cell Biology and minoring in Public Health. My interest in this committee draws from my studies in disease and its relationship to the community. I am particularly interested in the policies and actions that affect the accessibility of healthcare and treatment for populations from varying socioeconomic, ethnic, and social backgrounds. I hope to share this passion and interest along with you, allowing you to explore and discuss the critical issues the global health network must combat. This year will mark my 8th year in Model UN, and I'm so interested to see your perspective on this year's committee topics! I'm excited to see what you bring to the table at this year's committee! That said, I'm excited to introduce your Vice Chairs for this year's committee. Please read more about them below:

Emma Guard is thrilled to be one of your Vice Chairs for WHO! She is a third-year here at Cal studying Global Studies and Data Science, and she has chaired the FAO and NAM committees in previous sessions of BMUN. She has debated as a MUN delegate throughout high school and even attended BMUN virtually in 2021, so she's incredibly excited to enter the seventh year of her MUN career as a part of this wonderful committee! Outside of BMUN, she works as a research apprentice in the Political Science Department and is a part of the Cal Club Triathlon Team. In her free time, you can probably find her hammocking on the glade, roller skating, backpacking, or roaming around Moe's Bookstore.

Madelyn Diaz is a third-year student studying Legal Studies and Public Policy. BMUN marks the very first start of her six years of MUN experience, and she is very excited to help delegations of all debate levels improve their debate skills this year. Her interests are in educational and health equity policy, two issues that summarize the social inequities that communities of color continue to face in the present day. In her free time, Maddy has two moods: multitasking homework with romantic comedies (don't recommend!), or obsessing over her German shepherd puppy.

Nicola McDermott Catena is a first-year at UC Berkeley majoring in History. This is her 4th year of Model UN and her first time chairing at BMUN. In her free time, Nicola enjoys knitting, reading, painting, and binge watching Netflix originals. She is from San Francisco, and has attended SFMUN before, participating in UNESCO. As a Chair for the WHO, she looks forward to discussing with you the nuances and intricacies of adolescent mental health, and accessibility to blood.

Rhea Master is a first-year majoring in Molecular and Cell Biology. This is her fourth year of Model UN and her first time chairing a conference at BMUN. WHO is an exciting committee because it combines

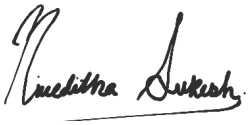
her passions for health and policy. In her free time, Rhea loves telling dad jokes, watching rom-coms, and trying new foods. Rhea cannot wait to meet all of you and hear all of your unique and interesting ideas during committee!

This year's committee topics introduce and revitalize concepts to health that you may have learned in school. The first topic of this committee is the international blood availability and transfusion safety. Before we get into the technicalities of this topic, there are a few points that are important to keep in mind. Despite being a medically-focused topic, our committee will take a holistic approach, and our dais hopes that you commit to exploring the political and socioeconomic facets of this topic in addition to the medicine. Whether it is in treating severe injuries, supporting surgical interventions, or managing chronic illnesses, blood transfusions are a critical pillar of modern medicine and ensure global health and well-being. Through ever-growing threats of disaster due to war, environmental emergencies, pandemics, and other unpredictable tragedies, the availability of blood across all nations, regardless of location or socioeconomic status, is crucial for medical professionals to effectively plan and respond to these critical situations. This level of access is just part of the equation. Safe blood transfusions, enabled by proper screening, testing, and handling are essential to preventing the spread of communicable diseases such as HIV, which disproportionately threaten low-income communities. The severity of this topic will require delegates to explore everything from regional blood distribution systems to the effects of blood donation on solidarity and compassion within a community. Breaking down this large scale issue in a new, smaller, light—with the help of the topic synopsis, of course—will help delegates take the necessary steps to give this topic the attention it deserves.

Our second topic is the decline and neglect of adolescent mental health. With the lasting impacts of the COVID-19 pandemic, the discussion of the role of mental health at home and in the workforce has increased tenfold. The impact has been even more prevalent on the adolescent population. According to the CDC, in the decade leading up to the pandemic, feelings of persistent sadness and hopelessness as well as suicidal thoughts and behaviors were already increasing by about 40% among young people. Adolescence is a time of exponential development both physically and mentally. The significant changes that shape the individual's personality, emotions, and cognitive abilities have a profound impact on their future outcomes. Because of the sensitivity of such growth, it is incredibly important that the proper care in both preventative and reactive measures are taken in the protection of the younger generation's physical, social, and long-term health. As you, the younger generation, I hope to see introspection in the importance of developing your mental growth, something that I was not completely familiar with during my high school years.

My hopes and intentions for this conference are to encourage you to explore new and creative ideas that cater to an cooperative and inclusive environment, addressing inequities and underserved populations.

Best,



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TOPIC A: INTERNATIONAL BLOOD AVAILABILITY AND TRANSFUSION SAFETY

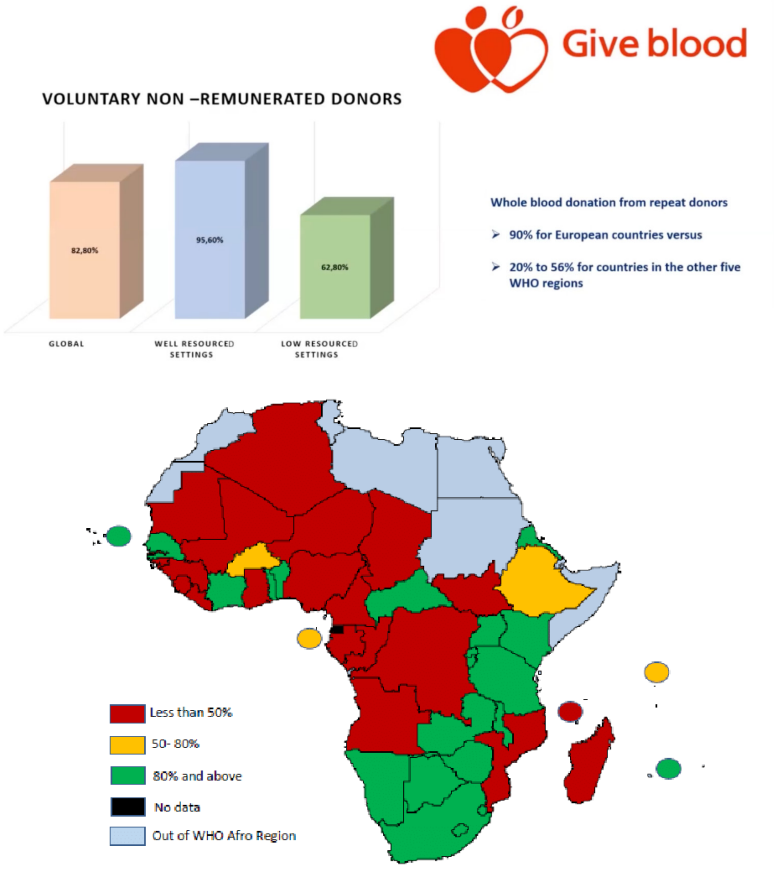
TOPIC BACKGROUND

What is Blood Transfusion?

A blood transfusion is a routine medical procedure in which donated blood or parts of blood are put into a patient's bloodstream through a vein. The blood may come from another person's donation or may have been taken from the patient and stored until needed. Such a procedure is vital in helping blood loss during surgery or injury and if an illness prevents the body from making blood or its components correctly (Blood Transfusion).

Transfusions heavily depend upon frequent and healthy levels of blood donations in order to meet the demands of patient populations. There are three blood donor types: voluntary unpaid, family/replacement, and paid donors (Blood safety and availability). With a larger emphasis on voluntary blood donation, roadblocks in planning and de-incentivizing ("without recognizable return") donation both nationally and internationally prove to be difficult (Woodfield Road blocks in achieving a 100% voluntary blood donation rate in the South Asian region). More so, blood screening is vital in order to properly administer it to patients as a life-saving treatment. While high-income and upper-middle-income countries are able to perform screenings following basic quality procedures, lower-income countries where transfusion-transmissible infections such as HIV, HBV, HBC, and syphilis is considerably higher are left vulnerable. This is largely due to the multiple roadblocks

and disparities in lower income areas, such as lack of a financial or health benefit from donating blood, which will be explained further later.



The average proportion of Voluntary non-remunerated blood donations in 46 countries of the WHO Afro Region in 2013

Figure 10(b). Age group donation rate (per 1000 population) in selected countries

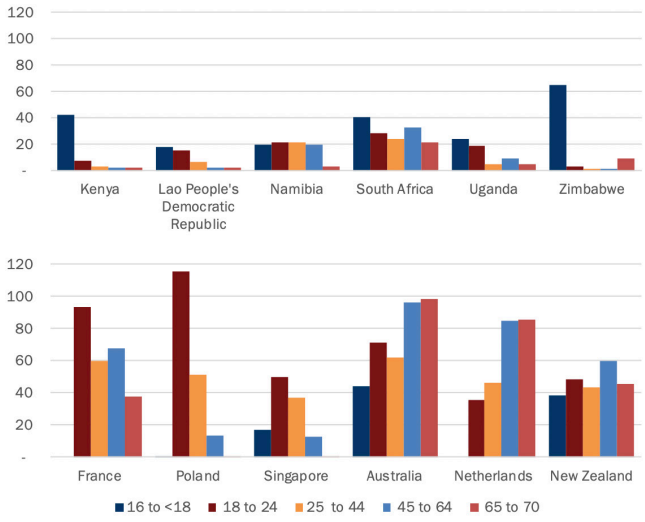
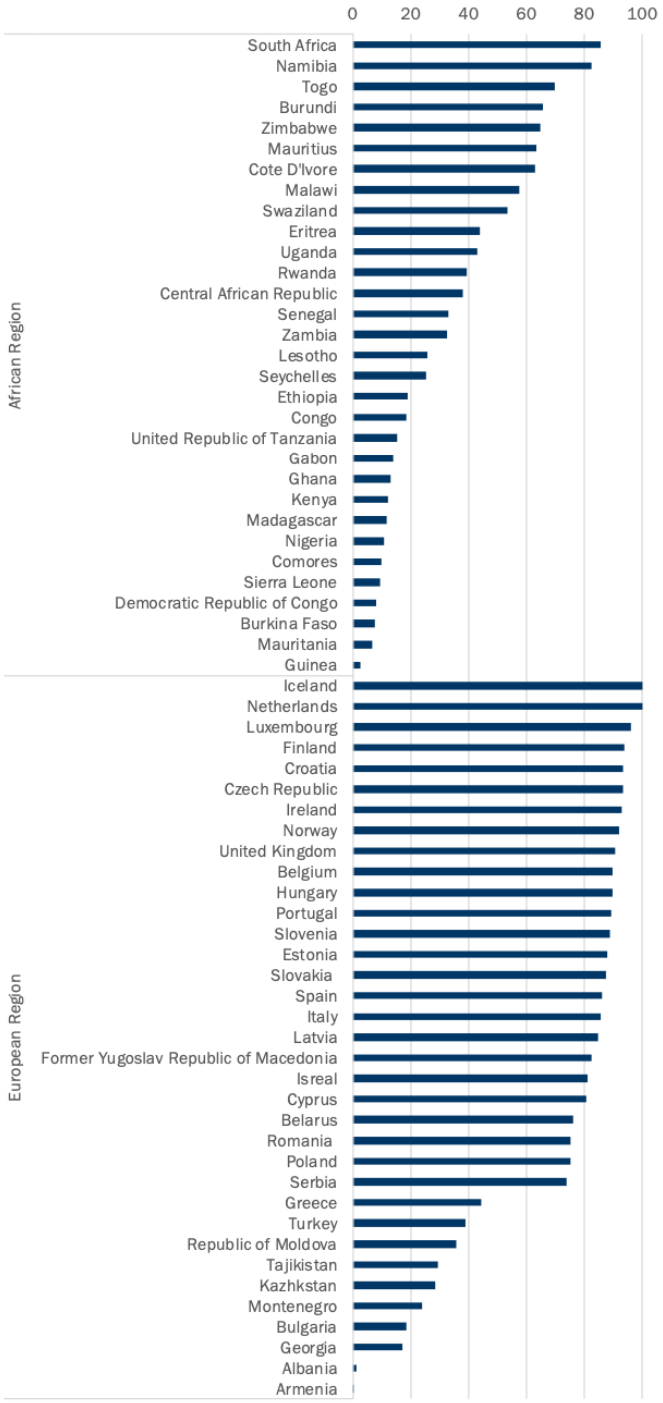


Figure 11. Donations by repeat voluntary non-remunerated blood donors in countries in the African and European Regions (%)



The difference in blood donors in the African region in comparison to the significantly higher rates in the European region reveal the gaps in efficiency as more developed regions have higher blood donor rates as well as the variation of disease among the populations (Blood safety and availability).

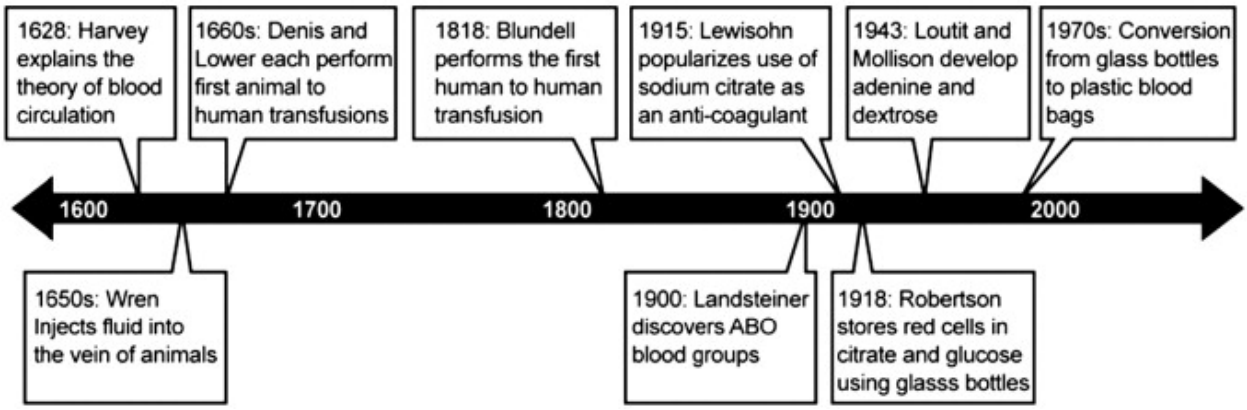
Table 1. Prevalence of transfusion-transmissible infections in blood donations (Median, Interquartile range (IQR)), by income groups

	HIV	HBV	HCV	Syphilis
High-income countries	0.002% (<0.001% – 0.01%)	0.02% (0.005% – 0.12%)	0.007% (0.002% – 0.06%)	0.02% (0.003% – 0.12%)
Upper middle-income countries	0.10% (0.03% – 0.23%)	0.29% (0.13% – 0.62%)	0.19% (0.07% – 0.36%)	0.35% (0.13% – 1.10%)
Lower middle-income countries	0.19% (0.04% – 0.62%)	1.70% (0.70% – 4.74%)	0.38% (0.12% – 0.99%)	0.69% (0.19% – 1.38%)
Low-income countries	0.70% (0.28% – 1.60%)	2.81% (2.00% – 6.02%)	1.00% (0.50% – 1.67%)	0.90% (0.60% – 1.81%)

Table 1. shows the numerical differences in the prevalence of infection in blood donations (Blood safety and availability).

A Brief History of Blood Transfusion

In 1665, the first successful blood transfusion was recorded by British physician Richard Lower by bleeding a dog almost to death and then reviving the animal by transfusing blood from another dog via a tied artery. Such an experiment was a monumental step in the growth of medicine. The first transfusion of blood for humans was in 1667 when Jean-Baptiste Denis performed the transfusion of blood from a sheep to a 15 year old boy and later to a laborer. By 1818, British obstetrician James Blundell was able to successfully transfuse human blood to a patient who had hemorrhaged during childbirth. In 1901, Karl Landsteiner, an Austrian physician, found the first human blood groups, establishing the basic principles of ABO compatibility. This meant that the discovery of the blood groups A, B and O increased safer transfusion practices as incompatible blood groups often led to blood clumping fatalities. In 1907, an American surgeon named Reuben Ottenberg suggested that patient and donor blood should be grouped and cross matched, leading to a safer blood transfusion procedure. By the 1920s, voluntary blood donation for storage and use was established (Highlights of transfusion medicine history).



(Pavenski, Katerina, et al. "Timeline of Red Blood Transfusion and Storage." ScienceDirect, Transfusion Medicine Reviews, 25 Aug. 2011, https://www.sciencedirect.com/science/article/abs/pii/S0887796311000629. Accessed 13 June 2023.)

Thus, during World War II, blood transfusion was used on a large scale to treat injured soldiers and became well-known as a living-saving procedure. Specifically, in 1941, the Red Cross began the National Blood Donor Service to collect blood for the US military. By doing this, it was possible for soldiers during the Pearl Harbor attack to be treated with albumin (a protein that helps keep fluid from leaking out of your blood vessels) for shock as well as dried plasma. By 1945, however, the Red Cross ended its World War II blood program for the military after collecting more than 6 million liters (World War II and the American Red Cross).

With the success of the National Blood Donor Service, the Red Cross began the first nationwide blood program for civilians in 1948, opening its first collection center in Rochester, N.Y. (From WWII to today: Blood Services helps patients across the U.S.). Notable accomplishments since include the invention of the blood bag instead of glass bottles to collect and store blood and withdraw blood for collecting different blood components. These measures led to the complex and established blood donation and transfusion system practiced globally today.

Process of Blood Transfusion

Before a blood transfusion is done, a sample of blood will be taken to check both the donor's and recipient's blood group to ensure that the blood is compatible. Typically, a single unit of blood can take between two to three hours to be given (four hours at most). Blood is usually given through a tiny plastic tube called a cannula, which is inserted into a vein in the recipient's arm. The cannula is connected to a drip, and the blood runs through the drip into the arm.

Because blood transfusions are common procedures that can save and improve lives, side effects are minimal, and death due to transfusion is extremely rare. Most patients who receive a blood transfusion experience no complications or problems.

With that being said, there are risks of blood transmitted infections including HIV, hepatitis B, hepati

tis C, hepatitis E, and syphilis due to infected blood donations, non-sterile environments, and improper screenings. In countries where screening is not conducted rigorously, these infections can lead to serious complications if not properly treated. The United States, Canada, Australia, Germany, France, Japan, Brazil and South Africa are just some of the many countries with robust screening programs.

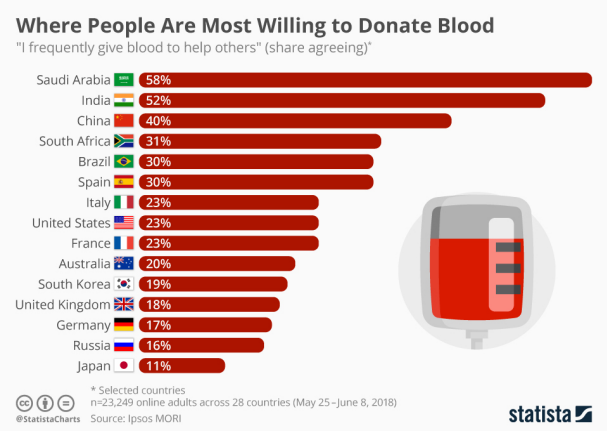
Number and percentage of transfusion-performing hospitals that conducted clinical audit, by WHO region

WHO region (countries)	Number of transfusion-performing hospitals	Number of hospitals that conducted clinical audit	Percentage
Africa (n=21[a])	1 539	114	7%
Americas (n=5)	3 183	1 207	38%
Eastern Mediterranean (n=5)	925	220	24%
Europe (n=15)	4 040	3 339	83%
South-East Asia (n=5[b])	3 262	1 884	58%
Western Pacific (n=16[c])	537	115	21%

[a] The 21 countries do not include Democratic Republic of Congo which reported that of 1459 blood transfusion-performing hospitals 875 (60%) conducted clinical audit.
[b] The five countries are Bhutan, Democratic People's Republic of Korea, Nepal, Thailand and Timor-Leste.
[c] The 16 countries are Brunei Darussalam, Cambodia, Cook Islands, Kiribati, Lao People's Democratic Republic, Malaysia, Micronesia (Federated States of), Mongolia, New Zealand, Niue, Papua New Guinea, Philippines, Singapore, Tuvalu, Vanuatu, and Viet Nam. Australia, China, Japan and the Republic of Korea reported that large numbers of hospitals performed blood transfusions, but did not answer this question.

Blood Donation Attitudes vs. Action

Because blood collection is primarily based on the ability of the country's population to donate, blood banks continually advertise and advocate for the donation of blood in order to meet the medical needs of a country. In different areas of the world, voluntary and unpaid donation can have different interpretations. In developed countries, while there are some variations in procedures, most are entirely dependent on unpaid voluntary blood donors (Woodfield 33-38). In Asia, however, a volunteer donor can still be remunerated in ways such as a meal, carton of goods, entertainment, time-off, or extra holidays (Woodfield 33-38). This could be why regions of Asia show the most willingness in populations willing to donate blood. However, culturally, there are still many myths in Asian countries about the blood donation side effects, such as blood donation leading to permanent weakness, infertility, accelerated aging, and exposure to witchcraft. These misconceptions, in addition to the fear of religious or familial disapproval, act as barriers to voluntary donation (Jenny, Hillary E et al.).



However, despite the differences in attitudes, countries in North America and Europe have higher donation rates in comparison to regions of Asia, Africa, and South America. This could be due to the multiple roadblocks and disparities in lower income areas such as:

- Lack of a financial or health benefit from donating blood
- Absence of policy and planning
- Inadequate leadership
- Poor staff training
- Problems of literacy and community education
- Inadequate financing
- Staffing problems
- Lack of use of community volunteers in blood donor recruitment
- Insufficient use of mobile blood collections
- Lack of quality assurance
- Lack of donor recognition

Let's take a look at a couple of the most notable obstacles in the war between attitudes and actions among countries with lower blood donations:

Expectations of a financial or health benefit from donating blood

The expectations of an impractical quid pro quo system of donation is not surprising in lower-income areas such as South Asia, where the incentive of food, time-off, and more has encouraged the donation of blood. However, a system of gratitude tokens has resulted in the expectation of reward among the population. To them, if blood has value, why should they give a non-remunerated voluntary donation to a governmental or non-governmental organization? Ultimately, the same individual must pay for a blood transfusion if they are ill, regardless if they took part in donation. Such logic, as well as the exchange of blood for compensation, is deeply ingrained and a significant hindrance in some Asian countries.

Combating these attitudes in lower income countries is a difficult process. Some Asian countries have established credit systems to enable "volunteer" blood donors to have free access to any blood needed for themselves or their close relatives. The credit system requires a computer program to ensure that donations are fairly distributed. A similar system was first conceived in the United States whereby any blood donations were credited to the individual, their family, or to a company (Woodfield 33-38). Singapore and Japan are some examples of Asian countries that have been able to develop successful voluntary systems without crossing boundaries separating incentive from payment by encouraging the population with powerful advertisement and outreach (Woodfield 33-38).

While such a solution appears to work in these countries, ideally, there should be no commercialized payment mentality in order to encourage voluntary blood donation. In Latin America and the Caribbean, recommendations and efforts to have 100% of blood and blood components donations come from voluntary and regular donors rather than family or friends of patients. However, the region is still far from reaching that goal with 48% of blood coming from voluntary donors in 2020—only a 2% growth from 2017 (PAHO calls for Solidarity after a 20% drop in blood donations in Latin America and the Caribbean during first year of the pandemic). While 100% voluntary donation systems are not likely to exist in the near future, countries such as New Zealand, Australia, and the United Kingdom have fully non-remunerated blood donor systems in which both the costs of blood services and charges to the patients for blood supplied are covered by taxation revenue. Thus, in a more long-term sense, such donor systems are possible with a more collaborative initiative and attitude.

Absence of policy and planning

Effective and streamlined voluntary blood donor service conducted by relevant political authorities is essential to maximize blood collection and transfusion and minimize hazards. For the development of a blood donor system, there should be a clear-cut framework for the overall management of a country's regional and national donor policies, meaning the government holds responsibility for the movement of blood.

Historically, organizations such as the Red Cross Society or other formal independent bodies delegated responsibility to organizations with little substantial input from the government. This means that the development of blood services is often carried out in a disorganized and aimless fashion, with little coordination or communication to all parties involved. New hospitals form new blood banks

without adequate coordination with other blood banks, creating competition for recruiting donors. No liaison between adjacent blood banks regarding supply and overall policies creates additional chaos (Woodfield 33-38). Even when there are formulated systems, there is often no follow-up and regulations are not followed, leading to the decline in assurance and return of blood donors. This can be seen in Brazil where the threat of diminishing blood supply led to the constant quest for blood donors until the Brazilian Ministry of Health Blood had to step in and make concerted efforts during the 1990's to change the blood donor supply from replacement first-time donors to community voluntary repeat donors (Carneiro-Proietti 918-25).

This means that governments must take a real interest in blood transfusion and develop a methodical and well-sourced plan in the relevant logistical coordination, legal considerations, and financial support necessary to blood collecting procedures and screening safety. Moreover, the need for local transfusion medical experts who can coordinate national planning, find ways to approach those in political control, and make them aware of the need for adequate planning procedures is essential (Woodfield 33-38). While medical personnel are typically reluctant to get involved in the political process, leadership from informed help is necessary as it is in national and international interest to have a high quality blood transfusion service. These political roadblocks must be overcome in some way if a voluntary blood donor service is to develop or to work through agencies such as the World Health Organization (WHO), the Red Cross or Red Crescent Society or other international organizations such as the International Society of Blood Transfusion (ISBT), as governments may more easily pay attention to their influential statements in order to maintain political power.

In essence, planning for effective blood safety in both donation and transfusion necessitates objectives with realistic dates and coordinated leadership. It may be impossible in most countries to have a 100% self-sufficient voluntary non-remunerated blood donor system, but with initiative and focus, development in improved systems of blood transfusion is attainable.

Lack of quality assurance

Although not as commonly recognized, quality assurance methods need to be applied to the blood donor system just as much as the very procedure of blood transfusion. Few blood transfusion services in lower income countries have dedicated quality assurance officers. Because of this, there is a lack of insight and initiative for assurance in the donor and transfusion world.

Neglect in such an area can lead to the dismissal of safety blood screening for infection and disease. In fact, transfusion transmissible infections (TTIs) such as Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) have prevalence in both high and low-income countries. In high-income countries, HIV, HBV, HCV and Syphilis prevalence are 0.003, 0.03, 0.02 and 0.05%, respectively (Aabdien, Mohamed et al, 617). The prevalence of these infections are higher in lower income countries at 1.08, 3.70, 1.03 and 0.90%, respectively (Aabdien, Mohamed et al. 617). More specifically, African and Pacific regions are the highest in HBV prevalence, Eastern Mediterranean region is the highest for HCV prevalence, Sub-Saharan Africa is the highest for malaria, and scattered foci in southwestern Japan, Colombia and intertropical Africa

are endemic for Human T-cell Lymphotropic Virus (HTLV-1) (Aabdien, Mohamed et al. 617).

The insurance of blood screening requires three key aspects in quality and provisional safety: adequate volume of blood supply, safe protocols for blood donation and transfusion, and appropriate regulation to ensure safe, equitable and sustainable distribution (Jenny, Hillary E et al.). Not surprisingly, low-income and middle-income countries (LMICs) experience a deficit in these categories. Blood volume from a steady and reliable stream of increasing voluntary donors is essential in closing the gap in blood availability as safer blood allows for higher blood availability in patients' living saving transfusions. However, as mentioned before, in many LMICs, blood donations come from a mix of voluntary, paid, and replacement donors. Safety protocols further increase quality insurance as it is pertinent to ensure that TTIs are not passed onto the donor or recipient.

Thus, quality assurance validates a countries' blood transfusion system by maintaining strict and strong donor as well as recipient safety during the life-saving process. By taking such precautionary measures, the incidence of TTIs can be significantly reduced. However, it is vital to consider means of regulation that will hold lower and middle income countries accountable. Without the resources and leadership, such practices can be impractical as consideration in a country's actual potential in accomplishing progress is vital towards planning resolutions.

Equity in Blood Availability and Access

Blood transfusion availability is not simply a result of low donation rates, fear of TTIs, or lack of government organization. Rather, it is also a product of low access to healthcare. Access to safe blood in low and middle income countries is incredibly difficult because most blood banks exist in urban areas as opposed to underserved and rural areas across the globe that likely need treatment the most. Many of these countries already struggle with obtaining a sufficient voluntary blood donation system to meet the needs of the overall population. But more so, the efforts to increase blood supply are hindered by various probationary policies of unbanked and directed blood transfusions, restricting the options of health practitioners, particularly in rural areas (Jenny et al. Access to safe blood in low-income and middle-income countries: Lessons from India). In such low-resource settings, key challenges in blood banking transparency, extending blood banks to rural areas, and affordable rates need to be addressed.

Even in high income countries access to healthcare is fraught with financial and administrative obstacles. In an analysis of 11 high-income countries' performance of healthcare, each system's access to care, care process, administrative efficiency, equity, and healthcare outcomes was measured. Surprisingly, despite spending exponentially more of its gross domestic product (GDP) on healthcare, the United States ranked last on access to care, administrative efficiency, equity, and healthcare outcomes. In contrast, countries like Norway, the Netherlands, and Australia ranked at the top. Thus, four features clearly separated the top performing countries from the rest: providing universal coverage and removing cost barriers, investing in primary care systems to ensure that high-value services are equitably available in all communities to all people; reducing administrative burdens that divert time, efforts, and spending from health improvement efforts; and investing in social services, especially for children and working-age adults (Jenny et al. Access to safe blood in low-income and middle-income countries: Lessons from India).

Clearly, access to healthcare is a common issue for all income level countries and requires grassroots attention and dedication to address. With accessibility increased, the availability of blood transfusions and donations can, in turn, also increase along with other valuable medical care.

Main Challenges in Universal Access to Safe Blood Transfusion

With such a background, the main challenges of universal access to safe blood transfusion can be narrowed down to seven main segments :

1. Organizational ones, such as fragmentation and low efficiency of blood services' operations, lack of tangible political commitment and support, and poor institutional coordination;
2. Inadequate financial resources or trained human resources;
3. Inadequate integration of blood transfusion services in health care systems and problems of geographically isolated communities of small populations;
4. Blood shortages, low donation rates, and high discard rates;
5. Considerable reliance on family/replacement and paid donations in many countries;
6. High prevalence of transfusion-transmissible infections in some regions;
7. A shrinking base of safe voluntary blood donors also contributes to unsafe blood transfusions (Universal Access to Safe Blood Transfusion).

PAST UN ACTION/INTERGOVERMENTAL ORGANIZATION RESPONSE

A Brief Overview

The World Health Organization has been dedicated to the cause of blood donor availability and issued resolutions over the last few decades attempting to decrease the gaps in accessibility and availability. The risk of increasing serious infections through unsafe blood and chronic blood shortages during the COVID-19 pandemic has brought further global attention to improving the situation.

Key UN Resolutions

- **1975: WHA Resolution WHA28.72: Utilization and Supply of Human Blood and Blood Products:** Helped to first introduce a system of voluntary non-remunerated blood donation.
- **1995: WHA Resolution WHA48.27: Paris AIDS Summit**: Successful in bringing attention to the blood transmissible infections.
- **1999: DC-PAHO/AMRO Resolution CD41. R15: Strengthening Blood Banks in the Region of the Americas:** Hyper-focused on the Americas' undevelopment blood system by establishing regional standards for the quality of blood banks and transfusion services.
- **2000: WHA Resolution WHA53.14: HIV/AIDS: Confronting the Epidemic**: Powerful in

- reducing the stigma towards HIV/AIDS in blood transfusion in Africa and Asia with establishment of stronger public education.
- **2001: RC-AFRO Resolution AFR/RC51/R2: Blood Safety Strategy for the African Region:** Helped to focus on the African regions public policies and strategies in ensuring blood parts' storage and transfusion was safer.
- **2005: WHA Resolution WHA58.13: Blood Safety: Proposal to Establish World Blood Donor Day**: Brought global attention to blood banks and the significance of blood donation in life saving medical procedures.
- **2007: WHA Resolution WHA60.24: Health Promotion in a Globalized World:** Helped to encourage education and improvement of public health policies in community lifestyle.
- **2007: WHA Resolution WHA60.29: Health Technologie:** Promoted the value of technology to help in the implementation of safe and effective healthcare directories.

Impact and Gaps in UN Action

Why have previous solutions been ineffective?

It is clear that the WHO has made efforts and recommendations for integrated strategies of improvement. However, commonly among these resolutions lies a lack of accountability. Countries, despite their desire to have a substantial blood storage as well as accessible healthcare system, are not all well equipped enough to carry out such resolutions. For some, organizational leadership is lacking; for others, attitudes and misinformation on blood transfusions barricades progress (Towards 100% voluntary blood donation: A global framework for action).

Despite this, progress is possible. Programs such as blood donor drives across schools in different countries have improved and educated younger populations on the importance of blood donations and safety. More so, the implementation of World Blood Donor Day has increased donations immensely.

Other intergovernmental bodies' parts in blood transfusion access have also helped significantly contribute to awareness and knowledge. For example, the International Society of Blood Transfusion (ISBT) is a scientific society founded in 1935 in which medical professionals from more than 100 countries share and disseminate knowledge from over 100 countries to improve the safety of blood transfusion worldwide. The society organizes international and regional congresses in places around the world in order to advocate for the welfare of blood donors and patients through the promotion of the ISBT "Code of Ethics," and ISBT is a Non-State Actor in official relations with WHO. One of the most notable contributions is the society's dissemination of up-to-date and well-sourced information with the purpose of guiding governments looking to improve transfusion policies. Moreover, the World Health Organization is a leading advocate for the implementation of healthy blood practices and improving access to healthcare. With many resolutions and guidelines published through the last few decades, blood transfusion services (BTS) around the world now have the responsibility to follow the policies and hold themselves accountable.

International Action and Response

Each region has different issues in working towards universal access to safe blood transfusion and thus, identifying differential challenges and constraints in order to prioritize needs is integral.

African Region

The African Region faces struggles in the sustainability of its national blood programs. It was identified that low policy implementation rate, inadequate financial resources, high prevalence of transfusion-transmissible infections, lack of quality systems and considerable reliance on family/replacement donations as the major gaps in achieving universal access to safe blood transfusion (Universal Access to Safe Blood Transfusion).

Americas Region

The Americas' largest obstacle is the lack of reliable data from blood services and hospital-based services as low resources present challenges in creating robust monitoring systems. The lack of understanding or education in the necessity of blood and blood products further hindered efforts. Moreover, high discard rates of blood collected in hospitals compared to the blood services was an important consideration for discouraging blood collection in hospital blood banks. Lack of leadership, oversight, and regulation of blood transfusion services and inadequately tested or untested blood were also noted as major issues (Universal Access to Safe Blood Transfusion).

Eastern Mediterranean Region

This region is a little different in the variation of level of development each country has. Most countries showed a high degree of fragmentation of blood transfusion services with natural or man-made disasters a constant threat to the region's stability. Aid management, dumping practices, and irrational clinical use of blood products are the main issues.

European Region

The European region identified the increasing need for blood to address the requirements of an aging population and a shrinking donor base as key challenges. With the movement of foreigners and locals between European countries, the dissemination of diseases has increased. Moreover, several countries are still dependent on paid donation and are unable to adequately screen all donated blood for infection. Cost-containment policies, lack of prioritization, and new technologies have further placed challenges to implementation (Universal Access to Safe Blood Transfusion).

Southeast Asian Region

Like the Eastern Mediterranean Region, there is strong diversity within this group of countries and the requirements for blood and blood products. However, there are seven key areas commonly in need of urgent attention: lack of political commitment and poor implementation of policies, lack of sustainable and adequate funding for developing services, limited program management capabilities, poor inter-sector collaboration with programs such maternal health, the need to identify factors of success and failures, misconceptions related to voluntary blood donation, and a lack of career structures for trained personnel (Universal Access to Safe Blood Transfusion).

Western Pacific Region

With varying big countries to small islands and strong economic diversity, there is a large discrepancy in accessibility between cities, rural regions and even islands. Additionally, the high prevalence of hepatitis B and HIV, a reliance on family donors (most likely

paid), the fragmentation of services with low efficiency, increased blood usage, and geographical isolation are the main barriers to a more streamlined blood donor system. Testing and screening for blood is varied, and many countries are still not testing 100% of donated blood for HIV (Universal Access to Safe Blood Transfusion).

Response: The International Red Cross and Red Crescent Movement

With a dedicated mission in universal and ethical service, the Red Cross and Red Crescent has been an integral piece in the movement towards healthy blood transfusion systems. With involvement in helping people in armed conflict, natural disasters, and blood drives, the society's influence has increased tenfold within the last decade (Fundamental principles).

CASE STUDIES

The COVID-19 Pandemic's Negative Impact on Blood Transfusion Services

The availability of and sufficiency of blood transfusions to meet patients' needs was a major issue as blood shortages, cancellation of blood drives, and social distancing or quarantining impacted the growth and sustainability of countries' blood banks. The ratio of blood donation significantly decreased by 40% especially during COVID-19 worldwide (Miskeen, Elhadi et al. 3063–3071). Such a deficiency revealed the importance and vitality of blood transfusion systems.

Influence of Pandemic on Healthcare Systems

Many blood centers experienced a decline in donations due to lockdowns, travel restrictions, and fears of infection. As a result, hospitals and healthcare facilities had to carefully manage their blood supplies to ensure that critical needs were met. Blood drives, which are essential for maintaining an adequate blood supply, were canceled or postponed to comply with social distancing guidelines and avoid large gatherings and thus, decreased the number of donations. Moreover, increased demand for convalescent plasma, a component of blood collected from individuals who have recovered from COVID-19, was used in some regions as a potential treatment for severely ill patients (Wang, Zhuo, and Hejian Wang 1593-1605). This led to an increased demand for convalescent plasma donations, putting additional strain on blood centers. Elective and non-essential surgeries and procedures were canceled and postponed, helping in some cases; however, the severity of the pandemic in different countries demanded appointment-based systems to manage donations.

Low Income Countries vs High Income Countries Response Strategies

It is important to note that the situation varies significantly between countries and regions. However, the most differential factors include the following (Loua A et al. 774-784):

1. Healthcare infrastructure
   Lower-income countries often face challenges in the healthcare system itself with limited resources, fewer blood centers, and inadequate equipment for blood collection, screening, and storage. Thus, lower income countries already hold a disadvantage in their ability to provide and adequately respond to the blood transfusion services compared to higher income countries with more robust healthcare systems.
2. Allocation of Resources
   In lower-income countries, the limited availability of resources and competing priorities in managing public health challenges resulted in reduced attention and resources allocated to blood transfusion services. Higher-income countries might have more flexibility and resources to bring attention to all aspects of healthcare such as blood transfusion services, even during a pandemic.
3. Blood Donation Rates
   Lower-income countries may already have lower blood donation rates due to cultural beliefs, lack of awareness, and limited access to donation centers. The pandemic could further decrease the donations due to fear and reduced mobility, while higher-income countries might have more established systems for blood donation and a larger pool of regular donors, which could help mitigate the impact to some extent.
4. Dependence on External Aid
   Some lower income countries rely heavily on international assistance from higher income countries and organizations for blood donations. The disruption of global supply chains and travel restrictions reduced the availability of external aid and resulted in greater challenges in maintaining an adequate blood supply.

In response, the WHO played a huge role in developing and disseminating an interim guidance on maintaining a safe and adequate supply of blood during the COVID-19 pandemic by recommending mitigating potential risk of transmission through blood transfusion, staff risk, and donor exposure to COVID-19; managing blood demand; ensuring undisrupted supply of critical materials and equipment; communicating to ensure that donors, recipients, staff, and the population are properly informed; and collection of convalescent plasma from patients who have recovered from COVID-19.

Significance

The pandemic overall was a stark reminder of the necessity in change towards accessibility and affordability of healthcare. The disruption of the healthcare system from the most simple to more complicated procedures revealed the vulnerabilities of each country's system of care. Countries, in response, had to prepare and plan policies to help respond to deficient blood supply.

Blood Product Contamination in South Africa

Overview

In the late 1990s, South Africa, as well as developing countries across the world, faced a significant public health crisis known as the "Blood Product Contamination Scandal." The scandal involved the sudden transmission of Human Immunodeficiency Virus (HIV) and Hepatitis C through imported and contaminated blood products from Cutter Laboratories. The financial investment in the product was considered too high to destroy the inventory and by selling the contaminated products to Asian, African, and Latin markets without any precaution of heat treating the product to help eliminate the risk, hemophiliacs (those who suffer from a disorder in which blood doesn't clot normally) who have extreme blood sensitivity developed AIDS (McHenry, Leemon, and Mellad Khoshnood 389-400). Thousands of patients, not only hemophiliacs, contracted infections.

In South Africa, during the 1980s and early 1990s, there was already unreliable HIV screening testing with resource constraints (Andersson, N, and S Marks 667-81). Because of this, blood banks struggled to identify and exclude HIV-positive donors effectively. In 1994, South Africa's political transition at the end of the apartheid led to changes in healthcare policies. Most importantly was the decision to provide free healthcare for all citizens, including blood transfusions. However, with limited resources, the implementation of robust blood screening practices faced difficulties.

During this period, the South African National Blood Services (SANBS) depended heavily on the importation of plasma products to help treat patients with bleeding disorders like hemophilia (About us - SANBS). These imported plasma products were often sourced from high-risk countries where HIV prevalence was significant.

This is when the Blood Contamination Scandal unfolded. Investigations and subsequents legal actions revealed that many of the imported plasma products were collected from paid donors, some of whom were intravenous drug users and at a high risk of HIV infection (The contaminated blood scandal). With the lack of adequate screening and testing protocols, the contaminated products entered the South African blood supply.

Impact & Significance

The scandal led to outrage and sparked public protests with affected individuals demanding justice. Accusations of negligence and misconduct against the South African government and the health authorities flooded the media and exposed the systemic issues of inadequate regulations, poor quality control, and a lack of transparency within the healthcare system. As a result, South Africa implemented strict screening measures, including mandatory testing for HIV and other infectious diseases to ensure the safety of blood products (About us - SANBS). Local plasma products also reduced reliance on imported products.

Thus, the Blood Product Contamination Scandal in South Africa during the late 1990s highlighted the necessity of detailed blood screening protocols and quality control. It served as a catalyst for reforms and improvements in not only the country but also across the globe.

QUESTIONS TO CONSIDER

1. How can you improve the efficiency of safe access to blood transfusion in your country? What are the largest barriers in your country's healthcare system?

2. How can blood screening tests be more efficient in countries with higher rates of blood transmitted infections?

3. How can countries reduce barriers in the decline of blood donations since the COVID-19 pandemic?

4. How can countries reduce the attitude of 'what's in it for me' that applies to the blood donation process and it is a common concept in many countries around the world, especially those with lower per capita incomes?

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TOPIC B: THE DECLINE AND NEGLECT OF ADOLESCENT MENTAL HEALTH

SIGNIFICANT TERMS

Cognitive Behavioral Therapy (CBT): a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, drug use problems, etc. It usually involves efforts to change thinking patterns and behaviors. These strategies might include learning to recognize one's distortions in negative thinking and then to reevaluate them (What is cognitive behavioral therapy?).

Disease Burden: The sum of mortality and morbidity is referred to as the 'burden of disease' and can be measured by a metric called 'Disability Adjusted Life Years' (DALYs) (Roser et al.).

TOPIC BACKGROUND

What is Mental Health?

According to the Constitution of the World Health Organization, health is defined as a state of complete, physical, mental and social well-being (Comprehensive Mental Health Action Plan 2013-2030). It is

not only the absence of disease or infirmity. Mental health can be influenced by a range of socioeconomic factors that need comprehensive strategies for promotion, prevention, treatment, and recovery that require a holistic governmental approach.

Especially in adolescence, a unique and influential time, physical, emotional, and social changes can make adolescents especially vulnerable to mental health problems. Today, there are an estimated 1.2 billion young people aged 10-19 in the world, making up the largest generation of adolescents in history (Khan, Yasmin et al 804-13). Adolescents with mental health conditions are particularly vulnerable to social exclusion, stigma, educational barriers, ill health, and human rights violations. Exposure to adversity, pressure to conform with peers, and exploration of identity are also significant factors. The tensions created from growing media influence and gender norms can further exacerbate the disparity between reality and personal aspirations for the future. WHO estimates that approximately one in five young people under the age of 18 experiences some form of developmental, emotional, or behavioral problem, and one in eight experiences a mental disorder (Khan, Yasmin et al 804-813). Common mental health disorders include emotional, behavioral and eating disorders; psychosis, self harm, and suicide are more behaviors that put adolescence in extreme danger.

Mental health promotion and prevention is especially vital in order to strengthen adolescents' ability to regulate and address emotions while preventing risk-taking behaviors and building resilience for managing difficult situations as well as promoting a supportive environment. With the COVID-19 pandemic, social distancing, as well as quarantine, has greatly exacerbated adolescent mental health issues (Theberath, Monique et al). Because of this, discussions of mental health in both adolescents and adults have exponentially increased. However, globally, governments have yet to fully strengthen policies and implement programs to protect the health of their citizens. Thus, it is vital to protect adolescents from adversity by promoting psychological well-being, as well as ensuring access to mental health care during adolescence and into adulthood.

A Brief History of Mental Health

Mental health has a long and tumultuous history with supernatural theories attributing mental illness to possession by evil or demonic spirits, the displeasure of gods, eclipses, planetary gravitation, curses, and sin. With the rise of medicine and the Greek physicians' rejection of supernatural explanations of mental disorders, superstition began to be superseded by research, theory, and science (Farreras History of Mental Illness). By 1908, the mental hygiene movement initiated by consumers of psychiatric services and professionals made great strides in improving the conditions and the quality of treatment of people with mental disorders (Bertolote World Psychiatry: Official Journal of the World Psychiatric Association (WPA)).

Culture vs. Mental Health

There has been a stigma surrounding mental health since the coining of the phrase "mental hygiene" by William Sweetzer in 1843 (Mandell Origins of Mental Health). In fact, it is largely because of this stigma that adolescent mental illness and health goes underdiagnosed and undertreated. According to the New Freedom Commission on Mental Health, mental health stigma is "a cluster of negative attitudes and beliefs that motivate the general public to fear, avoid, and discriminate against people with mental illness

es" (Adept The Dangers of Mental Health Stigma to Adolescents).

The labeling and isolating process of mental illness results in a type of devalued and discriminated attitude not only at an individual level, but also at a structural level in which institutional practices work to the disadvantage of those with mental illness (Elkington, Katherine S et al Perceived Mental Illness Stigma Among Youth in Psychiatric Outpatient Treatment). The effects of such stigma have considerable implications for adolescents who are developing identity and associated well-being. Thus, youth with difficulties may struggle even more when their need for structured and supportive environments is susceptible to the negative evaluation from peers or family in their environment. In India, for example, a study with the World Economic Forum surveyed a population asking general questions on their knowledge of mental illness and health. The study showed that 87% of respondents showed awareness of mental illness, yet 71% utilized strong terms that were rooted in stigma (Lobo Mental Health Around the World, Mental Illness in Other Countries). Every country and culture can be affected by mental illness. Thus, the discussion, understanding, and most of all, empathy of mental health is essential to the growth and overall prosperity of adolescent growth.

Main Systemic Issues

Given the prevailing impact of mental health disorders in children and adolescents, effective interventions need to be identified and implemented. The following are the most significant interventions in use:

School-based Interventions

School-based interventions are often key in reaching the youth population. It was found that focusing on mental health promotion rather than on mental illness prevention is effective in improving adolescent and youth mental health. However, school-based interventions can often lack organized leadership, theoretical foundations, process evaluations, or youth viewpoint (Das, Jai K et al Interventions for Adolescent Mental Health: An Overview of Systematic Reviews). Moreover, school-based therapy focused on solutions has mixed results in reducing intensity of negative feelings, managing conduct problems, and externalizing behavioral problems.

Specifically in low and middle-income countries (LMICs), school-based mental health interventions suggested a positive effect on students' self-esteem, motivation, and self-efficacy. Most programs in supporting depression prevention and early intervention were based on cognitive behavioral therapy (CBT) and also found to be the most effective in reducing depressive symptoms with effect sizes ranging from .21 to 1.40, meaning that the program had practical significance and applicability. School-based suicide prevention programs focused on screening, educating, and skills training. In indigenous youth (aboriginal) schools in Australia, suicide prevention programs

suggested increased planned evaluations and valid outcome measures necessary for prevention research (Das, Jai K et al Interventions for Adolescent Mental Health: An Overview of Systematic Reviews).

Community-Based Interventions

Community-based interventions included creative activities, parent training, and social skills training. It was found that community-based creative activities such as music, dance, singing, and drama suggest some positive effect on behavioral changes, self-confidence, self-esteem, levels of knowledge, and physical activity. Even more so, community-based parent training and social skills training for preventing depression suggested significant reductions in symptom and/or diagnostic measures. However, mental health promotion of young people in LMICs is uncommon and the few evaluations have shown a non-significant impact on improving mental health (Das, Jai K et al Interventions for Adolescent Mental Health: An Overview of Systematic Reviews).

Digital Platforms for Interventions

Mass media has an insurmountable influence on the youth and mass media-based behavioral treatments have actually shown to have a moderate effect, with computerized CBT for mental health being cost-effective and impactful. Online youth mental health promotion and prevention interventions similarly indicate that there is some influence on adolescent mental health. However, more extensive and rigorous research is essential to determine its effectiveness. Moreover, in LMICs, digital platforms may not be the easiest and most accessible form of resource as technology is expensive and prioritized for other needs.

Nonetheless, global systems require a multifaceted approach with delivery platforms in media, community, and school settings to be able to reach the adolescent population (Das, Jai K et al Interventions for Adolescent Mental Health: An Overview of Systematic Reviews).

Low-Income vs High-income Mental Health Service Policies

With more than 80% of people who have mental disorders residing in LMICs, mental illness is an important cause of disease burden. It is predicted that by 2030, depression is likely to be the third leading cause of disease burden in low-income countries and the second highest cause of disease burden in middle-income countries. In the state of Bihar, India, more people suffer from schizophrenia than that in the entirety of North America. Social factors such as poverty and internal migration as well as natural disasters and armed conflicts further exacerbate the incidence of mental and emotional health problems. Most of all, cultural views and biases against women and certain parts of communities can increase the burden of illness in these populations (Rathod et al. Mental Health Service Provision in Low- and Middle-Income Countries).

Each country in the LMICs group is in different areas of progression in mental health services. There is a wide variability and discrepancy between high need and persistent lack of financial resources, workforce, and infrastructure for mental health service. Comparisons between high and low income countries show that there is a significant difference in the mental health workforce. In the most populous developing countries of Asia and Africa—India, Pakistan,

Nigeria, and Ethiopia—the ratios of psychiatrists per 100,000 individuals are 0.301, 0.185, 0.06, and 0.04, respectively (Rathod et al. Mental Health Service Provision in Low- and Middle-Income Countries). Such low ratios indicate an overwhelming gap between countries' large population and low workforce of psychiatrists. Some high-income countries, such as the United States, have developed mental health systems, but such systems are ineffective, expensive, fragmented, and not focused on outcomes relevant for the service users. Thus, both in high and low income countries, focus must be placed in legislation and policy, finances and resources, and organization and planning.

PAST UN ACTION/INTERGOVERMENTAL ORGANIZATION RESPONSE

A Brief Overview

The World Health Organization set the first International Congress on Mental Health focused on mental health promotion and assistance since its establishment. In the past, WHO has developed the Helping Adolescents Thrive (HAT) Initiative with UNICEF in effort to strengthen policies and programs for the mental health of adolescents by monitoring mental health and prevention of conditions. The program also advocates for the prevention of self-harm and other risk behaviors that have a negative impact on the mental health of young people. WHO has also developed a module on Child and Adolescent Mental and Behavioral Disorders as part of the Mental Health Gap Action Programme(mhGAP) Intervention Guide 2.0., which provides evidence-based clinical protocols for the assessment and management of a range of mental health conditions in non-specialized care settings (Mental Health of Adolescents).

Key UN Resolutions

- Resolution WHA65.4: On the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

  Passed in May 2012, this resolution called for a coordinated response from health and social sectors at the country level and requested to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.
- Resolution A/HRC/RES/36/13: Mental health and human rights - Human Rights Council Resolution

  Passed in September 2017, this resolution recognized the importance of integrating mental health services into primary and general health care.
- WHO_FWC_MCA_14.05: Health for the world's adolescents: a second chance in the second decade: summary

  Released in 2014, the report re-evaluated care for adolescents, describing why adolescents need specific attention, distinct from children and adults. It presents a global overview of adolescents' health and

health-related behaviors, including the latest data and trends, and discusses the determinants that influence their health and behaviors

- EB148(3) - Promoting mental health preparedness and response for public health emergencies

  Passed in 2021, the resolution evaluated and proposed policies to help in the support of mental health as a result of the COVID-19 pandemic.

- WHA74.14: Comprehensive mental health action plan 2013–2030: ensures access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people.

  Building upon its predecessor Comprehensive Mental Health Action Plan 2013-2020, this plan promotes mental health and well-being for all to achieve universal coverage for mental health services. While the updated action plan includes new information, the original four major objectives remain unchanged: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research.

Impact and Gaps in UN Action

While the WHO remains committed to bringing light to adolescent care and assistance in mental health, the overall governmental fragmentation of mental health services, battling population cultural stigma and bias, and lack of well-educated resources has presented great difficulty in bringing significant change.

INTERNATIONAL ACTION AND RESPONSE

Despite a general increase of attention for Global Mental health (GMH) in academic, global health, and development discourses, the international community has struggled to take adequate financial and concrete measures to ensure this rise in GMH cognizance is truly global. GMH discourse is primarily Western, generated and funded by Western think tanks, implemented by Western NGOs, and largely missing an understanding of mental health in local contexts. In their homogenization of GMH, Western institutions often offer very reductionist perceptions that disregard mental health services as a primary issue in populations that also suffer with severe social and economic issues (Saraceno 1). This means that

health is viewed in one dimension wherein complicated diseases and behaviors can be better explained by "reducing" them into small, simple pieces (White, How does reductionism fit into psychology?). While helpful in educational terms, the reductionist perspective has led to the human body being understood as something physical, like a machine, where only fixing malfunctioning parts can restore overall health. This, and the publications of many Western researchers, especially over the past two decades, demonstrate an ideology that mental health services are somewhat of a "First World" commodity. In reviewing past and current international action as well as drafting solutions, delegates should keep in mind that Western research and theoretical modeling is often missing practical methods to implement proposed strategies in low- and middle-income countries.

The three-largest funders of global mental health research and strategy are Grand Challenges Canada, the U.K. Department for International Development, and the U.S. National Institute of Mental Health. These organizations have perpetuated exclusive research and strategies as the main funders and advisors of WHO mental health initiatives since the creation of the WHO's Mental Health Action Plan, but they have made strides towards inclusivity in their international action. Some of these more globally-inclusive solutions, deemed "North-South" or "South-South" strategies, aim to bear local contexts and perspectives in mind, some being spearheaded by local researchers (Collins 25). In addition to some formal international initiatives which will be discussed momentarily, research by these institutions have started to better address accessibility in their frameworks, advocating for care programs staffed by non-specialists such as peers and community health workers as well as smartphone-accessible screening and treatment (27).

One program of note includes the U.K.-funded Programme for Improving Mental Health Care (PRIME), which is a collection of research institutions that collectively aim to scale-up mental health services in Ethiopia, India, Nepal, South Africa, and Uganda. These institutions have focused on integrating mental-health services into primary care in a locally coordinated manner, informed by community advisory boards staffed by district health administrators, local health officials, local law enforcement, and traditional healers. In developing these advisory boards to coordinate locally-conscious solutions and adaptations, PRIME ultimately hopes to "observe cross-country differences and similarities in the evolving mental-health-care systems" on a global scale (Collins 26).

Basic Needs, another U.K.-funded program, is a global mental-health charity that provides access to employment and care for individuals with mental illnesses. Basic Needs has since refined their mission and expanded to include more mental-health-related issues and work in more low-income countries. The Basic Needs model has most recently been adapted in Ghana, Tanzania, Nepal, China, and Vietnam, often implemented by local charities that specialize in community-based rehabilitation alongside government-funded mental-health clinics (26).

The Mental Health Innovation Network (MHIN), funded by Grand Challenges Canada, also aims to coordinate international action. This online platform allows thousands of health officials and clinicians from around the world to contribute to collaborative research and policy advisory. Through this program, "more than 12,000 clinicians from 139 countries have participated in field trials, testing diagnostic guidelines in a wide range of settings" aiming to "break national, professional, and linguistic boundaries to facilitate global conversation and learning" (Collins 27).

These international programs have made significant strides in shifting mental health discourse towards greater local cognizance. However, it is critical to acknowledge the ways Western discourse has and continues to hinder GMH initiatives on an international level.

CASE STUDIES

Case Study 1: Australia's Mental Health Reform

Overview

Taking notable, concrete steps towards greater mental health strategy and finance, Australia committed to a decade's worth of mental health care investment and inclusivity through NSW Mental Health Reform 2014-2024 (NSW.gov). The nation's Mental Health Comission stated that they aimed to "put people—not processes—at the centre of the mental health care system," and cited nine key objectives as their immediate goals: integration of services, person-centered care, early intervention, strengthening community-based care, providing greater support for carers, suicide prevention, Aboriginal and Torres Strait Islander mental health, workforce development, and research and evaluation (NSW.gov). Noted in the aforementioned initiatives, Australia's commitment to better addressing and funding mental health services for its indigenous populations is an important step that other nations who partook in colonialism should embody as well.

Significance

The focus of NSW's Mental Health Reform 2014-2024 on indigenous population's mental health is of great significance, especially in a world where much of mental health discourse is spearheaded by Western research. This initiative aims to close the gap in mental health outcomes between indigenous and non-indigenous Australians, taking on key reforms such as incorporating traditional healing practices, acknowledging the importance of cultural identity in treatment, and prioritizing community engagement and indigenous voices in decision-making processes. It also works for promoting trauma-informed care, increasing data collection and monitoring to accurately track mental health outcomes in indigenous communities, and emphasizing awareness campaigns

NSW Mental Health Reform 2014 – 2024

Ensuring people with mental illness can live a better life and can participate in the community is a key commitment of the NSW Government.

In 2012, the Government established the Mental Health Commission of NSW and tasked it with the role of monitoring, reviewing and improving mental health and wellbeing for the people of NSW.

Under the leadership of Commissioner John Feneley, the Mental Health Commission of NSW consulted widely to develop a strategic plan for mental health care in NSW. The Commission's ten year road map *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* was adopted and released by the Government in 2014.

The plan sets out actions for reform of the mental health system in NSW and calls for collaboration between the government, the non-government and private sectors to improve outcomes for those living with a mental illness.

In December 2014, the NSW Government announced its response to the Commission's *Strategic Plan* - ***Strengthening Mental Health Care in NSW*** - and committed $115 million to commence the first stage of reform.

Key reform directions proposed by the Mental Health Commission of NSW and embraced by the Government include:

Strengthening prevention and early intervention, with a focus on high risk groups, such as children and young people. (**Wellbeing in Schools**)

Shifting the focus to community based care, including the transition of patients in long stay psychiatric hospitals into community based residential options, supported by strengthened specialist community mental health services (**Increasing Specialist Clinical Mental Health Services in the Community**, **Expanding Psychosocial Community Living Supports** and **Assisting Long Term Patients to Live in the Community**)

Developing a more responsive system, through investing in improved specialist services for people with complex needs (**Strengthening Specialist Support for People with Complex Needs**)

Working together to deliver person-centred care, through better integration between mental health services, mainstream health, justice and human services and Commonwealth funded services (**Local Innovation and Performance**)

Building a better system, through workforce planning, development of the non-government organisation sector, an investment in peer workforce initiatives and research and innovation (**Investing in Research**, **Investing in Workforce**)

The implementation of these reforms is being overseen by the Mental Health Reform Taskforce, led by the Secretary of NSW Health, and comprising senior representation from Family and

to reduce the stigma associated with seeking help (NSW Ministry of Health).

This initiative is simply a start towards addressing the stark divide in mental health outcomes in indigenous and non-indigenous populations, and demonstrates a necessary step that all modern governments should take to ensure the wellness of their indigenous communities. First Nations Australians still suffer disturbing levels of systemic abuse in addition to the decades of trauma imposed upon their communities, and these instances of racism and psychological distress demonstrate clearly that greater action must be taken to look out for the wellbeing of First Nations peoples (Butler 2).

Case Study 2: Nigeria's Gaps in Community Psychiatry Care

Overview

Psychiatric care worldwide is a burdensome challenge that affects LMICs at a greater level. Many people who experience mental illness are reluctant to seek help in fear of the stigma and negative impacts associated. With little information about the root factors that lead to avoidance of treatment, mental health treatment is particularly commonplace in LMICs. In countries such as Nigeria, such a burden of disease is enormous. According to the WHO, one in every four Nigerians have mental illness (Soroye et al. Community Psychiatry Care: An Urgent Need in Nigeria). As Africa's most populous country, Nigeria's system of mental health care can act as a representative example for the continent as a whole.

As the seventh-largest country in the world, Nigeria holds the highest caseload of depression and ranks 15th in the world for frequency of suicide. With less than 150 psychiatrists in the country of 200 million people, barely 10% of mentally ill Nigerians have access to the care they need. In stark contrast, the United States has about 28,000 psychiatrists for a population of 330 million people and the United Kingdom has 12,300 psychiatrists for a population of 68 million people (Soroye et al. Community Psychiatry Care: An Urgent Need in Nigeria). Such figures emphasize the urgency of more creative solutions to fill the gaps in care.

To note, many communities in Nigeria do not treat mental illness due to the stigma associated. There are various beliefs surrounding schizophrenia and depression and it is even taboo in some areas to even discuss such illnesses. Some view people with schizophrenia as witch- or demon- possession or as a spiritual attack and a punishment from God (R The Views of Some Selected Nigerians About Mental Disorders). Families may even go as far as to not allow relatives to marry into families with a history of mental illness. Studies report that the same discriminatory attitudes prevail among all peoples, including healthcare workers and clergymen (Tungchama, Friday Philip et al. Health Workers' Attitude Towards Children and Adolescents with Mental Illness in a Teaching Hospital in North-Central Nigeria).

With only seven government-owned psychiatry facilities in Nigeria, the facilities are always overwhelmed and there is a need to overhaul the existing policy to emphasize the urgency of a shift from inpatient psychiatric mental healthcare towards a community-based multidisciplinary psychiatric healthcare system. Thus, community psychiatry should be encouraged in the detection, prevention and early treatment of patients with emotional disorders. By placing emphasis on social and environmental factors that contribute to mental illness, initiatives can allow

social acceptances at a grassroots level.

Significance

In LMICs where the mental care situation is similar to that of Nigeria, developing a community policy for psychiatry is pertinent. By incorporating psychiatry care into primary healthcare services for assessment and short-term treatment of less severe and time-limited disorders such as anxiety and creating multi-disciplinary mental health teams, consisting of psychiatrists, community nurses, psychologists, pharmacists and others, the adverse situations can be remedied. Moreover, instituting comprehensive anti-stigma programmes and providing continuous education and support for parents and family members of the mentally ill patients can help to reduce stigma and open more positive discussion on mental illness (Soroye et al. Community Psychiatry Care: An Urgent Need in Nigeria).

The passing and implementation of policy on community-based psychiatry can serve as an example to LMICs across the globe in reducing stigma and increasing accessibility.

QUESTIONS TO CONSIDER

1. How can we improve access to mental healthcare to reduce stigma in lower-income areas?

2. With mental health risks found at different scales such as local threats that increase risk for families and individuals and global threats that heighten risk for whole populations with disease or forced displacement, how can these interacting determinants of mental health service enhance or undermine mental health?

3. What types of events/situations can place stress on a community's mental health and how can government agencies at the local, national, and supranational (AKA United Nations) level take steps to mitigate these stressors?

4. In what ways do you think your nation can best play a role in improving the mental health of its constituents? Are other nations facing similar problems? Is there a way that similar nations can collaborate to solve/address this topic?

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