MENTAL HEALTH IN HONDURAS

CHALLENGES AND STRATEGIES TO COVER THE GAPS

MEDICOS SIN FRONTERAS

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ACRONYMS

IASC: Inter-Agency Standing Committee

ICRC: International Committee of the Red Cross

IOM: International Organization for Migration

mhGAP: Mental Health Gap Action Program

mhGAP-IG: Mental Health Gap Action Program Intervention Guidelines

MHPSS: Mental Health and Psychosocial Support

MSF: Médecins Sans Frontières

NVO-UNAH: National Violence Observatory of the National Autonomous University of Honduras

PAHO: Pan American Health Organization

SESAL: Health Secretariat of Honduras

UNHCR: United Nations High Commissioner for Refugees

UNDP: United Nations Development Programme

USAID: United States Agency for International Development

WHO: World Health Organization

EXECUTIVE SUMMARY

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World Mental Health Day was established 26 years ago by the World Federation for Mental Health and the World Health Organization (WHO) to raise awareness of mental health problems and to eradicate myths and stigmas surrounding mental health.

For Médecins Sans Frontières (MSF) it is clear there is no health without mental health and the right to health must be granted in a comprehensive and equitable manner. A population that does not benefit from equitable and decentralized access to comprehensive services, faces a continued diminishment of their mental health, due to violence and increased vulnerability of structural gaps.

As a medical humanitarian organization, MSF regularly supports national institutions to raise awareness of issues concerning access to mental health services and suggests alternatives to alleviate these challenges, for example issues of access to services during the COVID-19 pandemic. Thanks to the adaptability of humanitarian teams, new tools have emerged enabling the continuation of Mental Health and Psychosocial Support Services (MHPSS). These services have been adapted to pandemic contexts and extreme violence.

This report seeks to contribute to a national reflection, to encourage and generate changes in favor of populations that do not have access to these rights and highlight structural gaps. It also aims to illustrate and emphasize the important role violence and COVID-19 plays in impacting mental health, particularly through the identification of vulnerable populations. Lastly, this report is intended to serve as a platform to present MSF's recommendations regarding the implementation of the Mental Health Gap Action Program (mhGAP), including the community approach.

In addition to the analysis within this report, MSF offers recommendations to all actors involved in mental health capacity building and response, including state institutions, and national and international organizations.

INTRODUCTION

Mental health is a fundamental right, and in Honduras demands immediate attention and concerted efforts to confront existing obstacles. This report by Médecins Sans Frontières aims to serve as a platform for ideas and practical solutions to address the urgent challenges in Honduras.

On October 29, 2021, in commemoration of the International Mental Health Day, the Secretariat of Health of Honduras (SESAL), the International Committee of the Red Cross (ICRC), the Pan American Health Organization (PAHO) and MSF joined forces for the inauguration of the III International Forum on Mental Health in Tegucigalpa.

One of the objectives of the event was to promote awareness-raising spaces where experiences and perspectives on the importance of improving access to mental health services at the national level could be shared. The presence of PAHO representatives, as well as the Honduran College of Psychologists at this forum, shows the breadth of interest and concern regarding access to mental health services for the thousands of underserved Hondurans.

The Honduran population has been historically affected by social, political, natural disasters and migration factors. This report contextualizes the mental health effects of the most vulnerable people associated with extreme violence, as well as those derived from the diverse impacts generated by the COVID-19 pandemic on the general population.

Gaps in mental health exist at different levels of public services and these manifests themselves in different ways depending on the needs of each population group, such as in the case of victims of sexual violence or catastrophes that have destroyed all the assets of an entire community. Through exploring solutions to these gaps this report includes a series of recommendations, including the vital implementation of the mhGAP program, aiming to guarantee sustainability and recognition of the mental health service in the community. The mhGAP program, promoted in most countries across the world, consists of facilitating access to mental health at the community level of primary health centers, through the training of health professionals who are not specialists in mental health.

Consistent with the WHO conclusions in their latest edition of the Mental Health Atlas (October 2021), showing that governments have not increased resources for mental health, thus contributing to the continued gap, MSF stresses that any strategy that seeks to alleviate the gaps and achieve the shared objectives requires more specific resources for mental health services.

One of the key components to accelerate the response at the primary level are the communities themselves, which have a wide range of resources, such as local associations, self-help groups, churches, schools, workspaces, among others that can be leveraged to promote mental health, prevent pathologies and support affected people.[1]

In conclusion, MSF calls for reducing structural gaps, accelerating the evolution of regulatory frameworks and decentralization practices of mental health services and care. Specifically, MSF emphasizes the need to recognize the vulnerabilities associated with mental health needs and response capacities. MSF supports solutions and alternatives adapted to the specific profiles of the most vulnerable populations, in addition to the contexts that exacerbate their vulnerability. In this respect, MSF provides alternative recommendations to governmental agencies and competent entities to join efforts and provide quality mental health care, promoting prevention and access programs at the community level.

1 Abello, R. & Madariaga, C. (1997). *Social networks as a survival mechanism: a case study in sectors of extreme poverty.* Latin American Journal of Psychology, 29, 115-137.; Palomar, J & Lanzagorta, N. (2005). *Poverty, social resources and social mobility.* Latin American Journal of Psychology, 37, 9- 45.

I - OVERVIEW OF MENTAL HEALTH IN HONDURAS

1. THE IMPACT OF VIOLENCE IN THE COMMUNITY

The Honduran population has historically been affected by a series of climate, social and political factors, which have had a significant impact on its mental health. The causes, which continue to accumulate over time, include a context of permanent violence that incites migration, coupled with natural catastrophes and the latest COVID-19 pandemic.

Honduras, has 9.9 intentional homicides per day per 100,000 inhabitants. It remains one of the countries with the highest intentional homicide rate in the world, without experiencing an internal armed conflict [2] according to the National Violence Observatory of the National Autonomous University of Honduras (NVO-UNAH). 258 homicides were registered in the first half of 2021.[3] This figure reflects a 16% increase compared to 2020.

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In the specific case of women and girls, by mid-2021 there are more than 160 femicides. The NVO indicates that between 2005 and 2020, 6,541 women have died violent deaths, of which 61.5% of the cases investigated have been registered as femicides. This clearly shows a violation of dignity based on power relations and vulnerability accentuated by gender.[4]

A study conducted in 2020 by the Infosegura/UNDP (United Nations Development Program)/USAID (United States Agency for International Development) Regional Project on violence against women in Honduras, reported that in 2020, the 911 emergency call system exceeded 100,000 calls for domestic violence (57%), and intrafamily (43%). Between 2017 and 2020, reports of domestic violence where the victims were women increased by 24%. In contrast, there were 2,461 sex crime complaints in 2020, reflecting a 27% reduction from 2019. To understand this reduction, it is important to consider the mobility restrictions imposed during the beginning of the pandemic on access to health and justice services. In addition, it should be emphasized that there continues to be a feeling of impunity and a significant lack of access to adequate services for these victims. This last point is due to the lack of a National Protocol for the comprehensive care of survivors of violence and sexual violence.

Considering that MSF has been intervening since 2011 in the areas where most of the violent deaths of women are concentrated, specifically in the municipalities of Distrito Central, San Pedro Sula and Choloma, the organization has witnessed first-hand the general health consequences that this violence generates among women, and especially to their mental health.

2 2 SwissInfo (s.f.). Homicides in Honduras rise to 6.7% and exceed 2,700 in the first nine months of 2021. Refenced from: https://www.swissinfo. ch/spa/honduras-violencia_los-homicidios-en-honduras-suben-6-5- --y-superan-los-2.700-en-9-meses-de-2021/47005414; SEPOL (s.f.). Historical homide rates. Refenced from: https://www.sepol.hn/sepol-estadisticas-honduras.php?id=138

3 Vargas, Y. (08 July 2021). *NVO: First half of 2021 recorded 258 more homicides compared to 2020.* University Presence, UNAH. Available at: https://presencia.unah.edu.hn/noticias/onv-primer-semestre-de-2021-registro-258-homicidios-mas-en-comparacion-con-el-2020/

4 Vargas, Y. (08 July 2021). *NVO: First half of 2021 recorded 258 more homicides compared to 2020. University Presence*, UNAH. Available at: https://presencia.unah.edu.hn/noticias/onv-primer-semestre-de-2021-registro-258-homicidios-mas-en-comparacion-con-el-2020/

VIOLENCE AND MENTAL HEALTH - TESTIMONY OF AN MSF PSYCHOLOGIST - CHOLOMA:

While conducting an intervention with the Mobile Unit team in the Choloma park, I attended to the case of a young woman who requested psychological assistance while she was looking for a job. During the initial interview, she seemed very unbalanced, insecure, fearful, and embarrassed. In her stories she commented that, for a long time, she and her two children had been victims of physical, verbal, and psychological violence by her partner, who suffered from a drug addiction. When he came home in this state, he physically abused her and their two children. She also shared that in the past he had pushed her to provoke an abortion. In addition to this, the patient expressed that she was a survivor of an attempted rape, had a gestational loss and several suicide attempts in her adolescence. She reported that, because of these events, she decided to leave her ex-partner and moved to another house with her children. She then began to receive constant threats of violence and threats to take her children away from her if she did not return to him.

The work with this patient started from the first intervention. Considering that from that first interview the patient entered into crisis, psychological first aid, support and emotional accompaniment were provided. Given her fear for her life and that of her children, her treatment included the assessment of alternatives to reduce her vulnerability and a safety plan was developed together with the patient. The case was then referred to our social worker, so that she could liaise with the relevant organizations and thus provide her with protection.

She was distressed by her ex-partner's visits to her son, since when she was present, she was psychologically abused. During the psychotherapeutic intervention, alternative solutions were considered. She decided not to attend the visits and instead to send her son with a relative. An assessment of irrational ideas was also conducted to reduce anxiety, and in cases where real risks were identified, action was taken. In September, when she went out to pick up her son after one of the visits, he destroyed her home. She said, "He has been trying to kill me for days now, and he won't be calm until he does". In the session following the incident, psychological first aid was provided, and she was reconnected with social work to obtain legal assistance in order to file a complaint and proceed to take legal action in the custody of the child.

In the last intervention, she reported feeling at peace and less afraid, ready to work. She mentioned that evaluating her thinking has been a very important tool for her. During the process we sought to empower her in her rights and reintegrate her into the labor and social world. This patient is an example of how, despite the paralyzing fear, suffering, shame, and guilt she felt, she was able to strengthen herself, raise her voice, and break the cycle of violence.

Identifying information has been changed to protect patient confidentiality.

THE SITUATION OF THE MENTAL HEALTH SYSTEM IN HONDURAS 2017

Total number of mental professionals: 185
Ratio of mental health specialists per 100,000 inhabitants:

Professionals	Psychiatrists	Pedo-psychiatrists	Psychologists	Social workers
2.06	0.66	0.01	0.62	0.23

Source: WHO (2018). *2017 Mental Health Atlas – Honduras – Member state profile.* Geneva

The percentage of government mental health budgets globally has barely changed in recent years, remaining around 2%.[5] In the 2020 edition of the WHO Atlas, we can see that, globally, psychiatrists remain a scarce human resource, with an average of only 1.7 psychiatrists per 100,000 inhabitants.[6] However, this gap is more problematic in those countries where their societies are prey to social, structural and generalized violence.

According to 2017 figures, the budget dedicated to mental health in Honduras is 1.6% of the government budget for the health sector.[7] This figure clearly illustrates the lack of recognition of this important sector. For this reason, MSF's key recommendations include increasing the budget dedicated to human resources as a high priority, their training, provision of space and infrastructure required for their work.
It is within these circumstances of limited services and the humanitarian need generated by consequences of violence in all its forms, that MSF continues to be present in Honduras offering comprehensive medical care to survivors of all forms of violence and sexual abuse. In Tegucigalpa and in the municipality of Choloma, MSF provides care to victims of violence and sexual violence, providing sexual and reproductive health support, and in San Pedro Sula the organization provides care to sex workers and the LGTBIQ+ population.

To illustrate the necessity of MSF's work, between 2016 and October 2021, MSF teams have provided mental health care to 3,254 victims of gender-based violence. To reach them, MSF teams are constantly moving within communities, enabling access to health, giving medical and psychological care. There is a clear demand, with various issues observed of which some of the main symptoms identified by colleagues are related to depression and anxiety.

5 WHO (08 October 2021). *WHO report highlights global shortfall in investment in mental health.* Available at: https://www.who.int/news/item/08-10-2021-who-report-highlights-global-shortfall-in-investment-in-mental-health

6 WHO (2021). 2020 Mental Health ATLAS. Available at: https://www.who.int/publications/i/item/9789240036703

7 Mental Health ATLAS (2017). Available at: https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2017-country-profiles/hnd.pdf?sfvrsn=8920bb6d_1&download=true

Until June of this year, MSF also assisted the population of the department of Cortés, affected by the damage caused by hurricanes Eta and Iota. Meanwhile, in Tegucigalpa, MSF assisted people affected by the pandemic and, more recently, supported people on the move on their migratory route to northern countries.

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2. POPULATIONS FACING ADVERSITIES

When emergencies arise, whether natural or man-made, the people affected may or may not develop psychological problems or disorders. Social, emotional, and biological factors interact and influence the affected people and may serve as catalysts in the development of psychological problems or, conversely, may serve to strengthen resistance and resilience in the face of adversity.

The context of each emergency defines, therefore, not only the factors mentioned here, but also the groups of people who are most at risk of experiencing social and/or psychological problems. This is why, beyond the general assistance and protection responses that should be offered to people affected by the emergency, it is important to identify in each incident the specific vulnerable groups and their particular needs, so that during response planning, treatment is adapted according to their needs.

The IASC Guidelines on Mental Health and Psychosocial Support in Humanitarian Emergencies and Disasters have established a good basis for identifying these highly vulnerable groups: they are listed below[8].

2.1 WHO ARE THE GROUPS OF PEOPLE MOST AT RISK?

- Pregnant women, single mothers, widows, and adolescents
- Men who are former members of security or armed groups, unemployed men who have lost the means to support their families, young men who are at risk of arrest, abduction or targeting for violence
- Children, including children from birth to 18 years of age, who may be separated from their families or unaccompanied, orphans, those recruited by armed groups, victims of trafficking, those in conflict with the law, in street situations, malnourished or working in dangerous places
- Elderly people, particularly when they are in a situation of abandonment or have lost family support (especially when they have lost family caregivers)
- People in extreme poverty
- People in mobility, such as internally displaced persons, asylum seekers, refugees, and migrants in an irregular situation or without identification documents
- People who have been exposed to extremely traumatic events, such as those who have lost family members or livelihoods, as well as survivors of rape and torture, witnesses of atrocities, etc.
- Persons suffering from pre-existing severe physical, neurological, or mental disabilities or disorders
- Persons confined in protective institutions, such as orphans, the elderly, persons suffering from disorders or disabilities
- Persons who are subject to severe social stigma, such as sex workers, survivors of sexual violence, and the LGTBIQ+ population
- People who are at particularly high risk of human rights violations. Among them are political activists, ethnic or linguistic minorities, persons in institutions or in detention, persons who have already been exposed to human rights violations in the past, and persons who are at particularly high risk of human rights violations

2.2 THE COMPLEX SITUATION OF POPULATIONS ON THE MOVE

Among the populations mentioned above, people on the move form a group that is intrinsically vulnerable and equally diverse, potentially consisting of all the populations mentioned in the previous section. In addition to the risk factors identified in their place of origin, their experiences of displacement increase their risk of experiencing social and/or psychological problems.

For decades, hundreds of thousands of Hondurans have been forced to move internally and internationally, due to the context of extreme violence that endangers their lives. Although the most recent figures from the Public Prosecutor's Office[9] and the UNDP[10] show a relative decrease in homicide and femicide rates at the national level, other forms of violence associated with cases of threats, usurpation and dispossession of homes force Hondurans to move internally or to other countries.

In this regard, according to a study conducted by the UN Refugee Agency (UNHCR), at least 247,000 people have been internally displaced in Honduras between 2004 and 2018 due to violence.[11] International asylum seeking has also seen a sharp increase.

8 Inter-Agency Standing Committee (2007). *IASC Guidance on Mental Health and Psychosocial Support in Emergencies*. Ginebra.

9 SEPOL (s.f.). *Historical homicide rates*. Available at: https://www.sepol.hn/sepol-estadisticas-honduras.php?id=138

10 UNDP Honduras (04 June 2021). *Analysis of violence against women in Honduras 2020*. Available in: https://www.hn.undp.org/content/honduras/es/home/presscenter/articles/2021/analisis-de-violencia-contra-las-mujeres-en-honduras-2020.html

11 UNHCR (08 may 2021). *UNHCR Deputy High Commissioner visits Honduras to reiterate her support to address forced displacement*. Available at: https://www.acnur.org/noticias/press/2021/5/6096f5da4/alta-comisionada-adjunta-de-acnur-visita-honduras-para-reiterar-su-apoyo.html

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This was reflected in Mexico, where more than 35,000 Hondurans applied for asylum in 2021 alone; representing a 16% increase over 2019, a year that saw record numbers of departures.

The International Organization for Migration (IOM) highlights in its report *Migration Profile of Honduras* the changes occurring not only on the migratory route, but also in the type of people who migrate. [12] The causes are multiple, including economic factors such as family reunification, violence, the effects of climate change and food insecurity. It should be noted that the most vulnerable groups increasingly represent a significant proportion of people on the move. According to the same organization, women will account for 48% of the 272 million migrants in the world by 2020.[13] This also reflects that the causes of displacement have become more feminized. On the other hand, the number of unaccompanied minors identified at the U.S.-Mexico border has increased 188% between 2020 and 2021.[14]

MSF teams have also observed a significant increase in the number of people transiting through Honduras, often from non-Spanish-speaking backgrounds. It is estimated that from January to November 2021, more than 125,000 people from the south, mostly Haitians, transited through Honduran territory in search of a better quality of life.[15]

However, the causes of displacement and mobility, including deportations, the population in transit, and violence along the route have not evolved in a significant way to foresee a reduction in the trends identified in recent years. Therefore, it is estimated that migration phenomena will continue to grow both regionally and nationally, and, proportionally, mental health needs will remain the same or increase.

The numbers of deportations to the country alone provide a reading of the overall volume of people who have left the country. According to Voice of America,

12 International Organization for Migration (2020). *Honduras Migration Profile 2019*. Available at: https://publications.iom.int/system/files/pdf/mp-_honduras-2019-es.pdf

13 International Organization for Migration (s.f.). *World Migration Report 2022*. Available at: https://publications.iom.int/

14 U.S. Customs and Border Protection (s.f.). *Southwest Land Border Encounters (by Component)*. Available at: https://www.cbp.gov/newsroom/stats/southwest-land-border-encounters-by-component

15 Panama's National Migration System (s.f.). *Irregular transit of foreigners across the border with Colombia by region, by order of importance: year 2021*. Available at: https://www.migracion.gob.pa/images/img2021/pdf/IRREGULARES_POR_DARIÉN_NOVIEMBRE_2021.pdf

MIGRATION AND MENTAL HEALTH - TESTIMONY OF A PSYCHOLOGIST FROM THE MOBILE TEAM IN TEGUCIGALPA

The migrants we serve in the mobile team have gone through many difficult situations along the way. Most of them arrive with symptoms of acute stress and worry. They often synthesize without details and point out that what they have lived through in the jungle will never be forgotten. Others report having lived through situations they had never previously experienced, such as seeing people killed on the road, being assaulted, or threatened under intimidation with knives or firearms, witnessing or surviving incidents of sexual violence. Seeing people being swept down rivers or falling off cliffs and hearing stories of people being killed.

I recall the case of a woman who commented how the group she was traveling with in the Darien jungle was assaulted by six people they identified as 'Indians'. Three of them sexually assaulted her and another girl in front of the others. The patient was very emotionally affected. She said that these men were like animals and did not mind doing this to her in front of their partners and children. That was what hurt her the most.

We worked with her on some breathing exercises and talked about the thoughts, emotions, and reactions she was experiencing after what happened. At the end of the consultation, she was grateful and calmer.

She expressed that after that event she felt pure sadness and talking to a professional about how she was feeling was restorative, it allowed her to unburden herself. Minutes later she boarded the bus that would take her to the border to continue her journey with her partner and son.

This is just one of many everyday examples shared with us by people on the move that reflect the state of their mental health. To work with these people, whose mental health needs are particularly high, MSF employs the strategy of single-session therapy as a specific strategy adapted to contexts where follow-up with patients cannot be assured. However, there is also the opportunity to follow up through remote counseling, for which a phone line and WhatsApp platform have been adapted to facilitate contact.

Identifying information has been changed to protect patient confidentiality.

between January and November 2021, more than 41,000 Hondurans were deported from Mexico or the United States, representing an increase of 33.8%.[16]

Faced with this scenario, MSF and other organizations at the regional level strive to provide comprehensive care along the migratory route. In MSF's specialized response, it has been observed that mental health is one of the most important issues affecting this population. As mentioned above, people on the move are at high risk of living, either in their place of origin and/or during their transit, traumatizing experiences.

MSF therefore advocates that people on the move should receive comprehensive assistance along the route from local authorities, respecting their safety and human dignity. This comprehensive assistance must include specialized mental health care and be adapted to the nature of their mobility, to prevent and alleviate the mental suffering of these people. Likewise, this assistance should support and provide tools to help with resilience and to confront dangerous situations on a daily basis.

16 Voice of America (03 December 2021). *Honduras reports 33% increase in deportations from U.S. and Mexico. Available at*: https://www.vozdeamerica.com/a/observatorio-de-honduras-reporta-aumento-de-deportaciones-desde-ee-uu-y-m%C3%A9xico-en-m%C3%A1s-del-33-/6338865.html

3. PRESENTATION OF MÉDECINS SANS FRONTIÈRES

Since 2016, MSF psychologist teams have provided more than 21,000 consultations to the Honduran population. In that year, it was identified that 80% of the victims were women and 34% were minors. It should be noted that 40% of these minors were victims of rape. Of the total number of cases, 6,174 cases were identified as victims of violence, 2,662 cases were victims of sexual violence, and 3,512 cases corresponded to other situations of violence, such as urban violence, domestic violence, victims of threats, human trafficking or smuggling, indirect victims or witnesses of violence/murder/threats, and forced internal displacement.

6,174
cases were identified as victims of violence

2,662
cases were victims of sexual violence

Since 2016, MSF psychologist teams have provided more than 21,000 consultations

40% of these minors were victims of rape

34% were minors

80% of the victims were women

II. THE IMPACT OF THE COVID-19 PANDEMIC ON MENTAL HEALTH

1. IMPACT OF THE PANDEMIC WORLDWIDE

The COVID-19 pandemic has not only accentuated institutional weaknesses in responding to public health emergencies but has also demonstrated the negative impact on the mental health of the population in general, and in particular on the most vulnerable population groups. The uncertainty associated with this disease, plus the effect of social distancing, isolation, and quarantine, have aggravated the mental health of the population.

In 2020, WHO conducted a study consisting of 130 countries with the objective of identifying the disruptions generated by the pandemic on essential mental health services.[17] The impact of the pandemic on the population was reflected as follows:

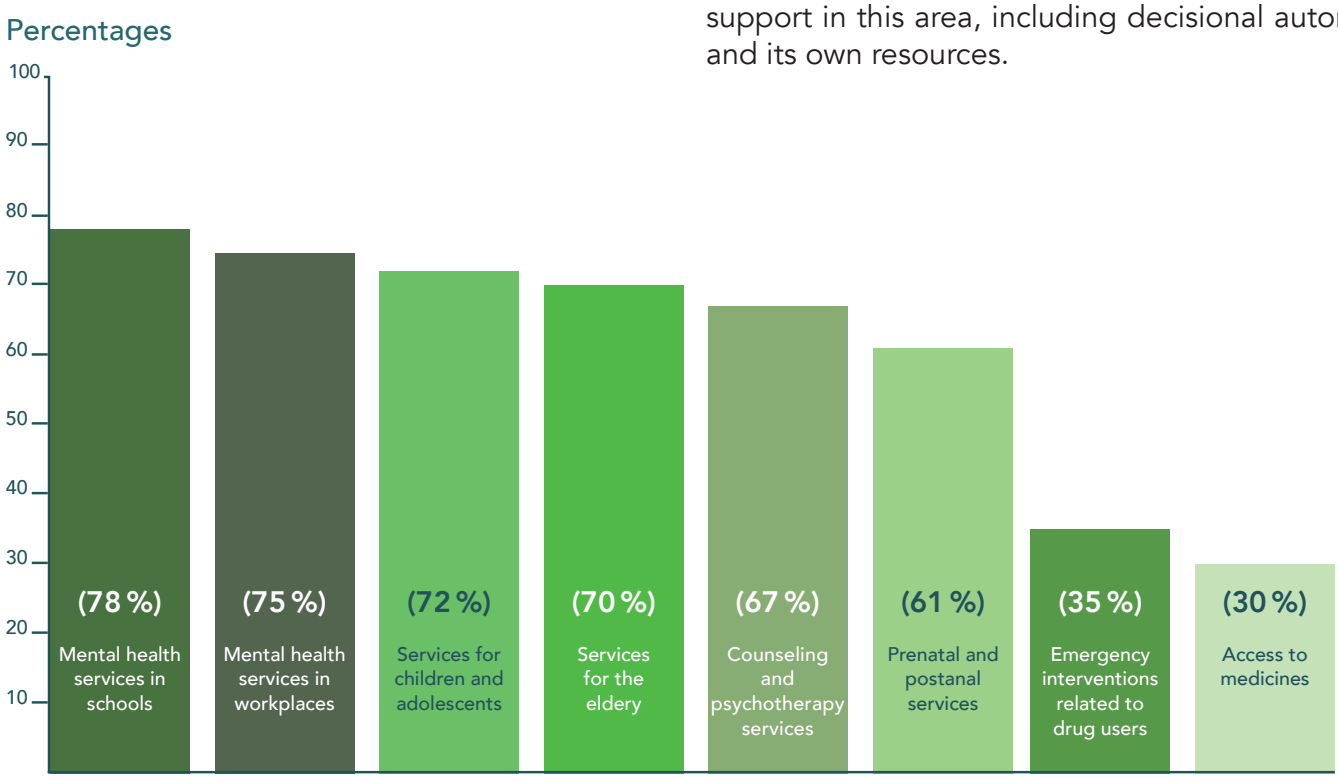
More than 60% of the countries reported disruptions in mental health services for vulnerable people, including:

- Services for children and adolescents (72%)
- Services for the eldery (70%)
- Services dedicated to women requiring prenatal and postanal services (61%)
- Counseling and psychotherapy services (67%)
- Emergency interventions related to drug users, including those for people affected by prolonged seizures and severe withdrawal syndromes (35%)
- Access to medicines for the treatment of mental, neurological and drug use disorders (30%)

17 OMS (05 October 2020). *Mental health services are being disrupted by COVID-19 in most countries, according to WHO study*. Press release. Available at: https://www.who.int/es/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey

- Mental health services in schools and workplaces (78% and 75% respectively)
- Global disruption to mental health services for vulnerable people due to the pandemic

MSF identifies from its perspective that resources are even more limited when the institutional response does not have a formal structure to which specific resources are allocated. In this regard, MSF agrees with other international studies that underscore the importance of increasing investments and institutional support in this area, including decisional autonomy and its own resources.



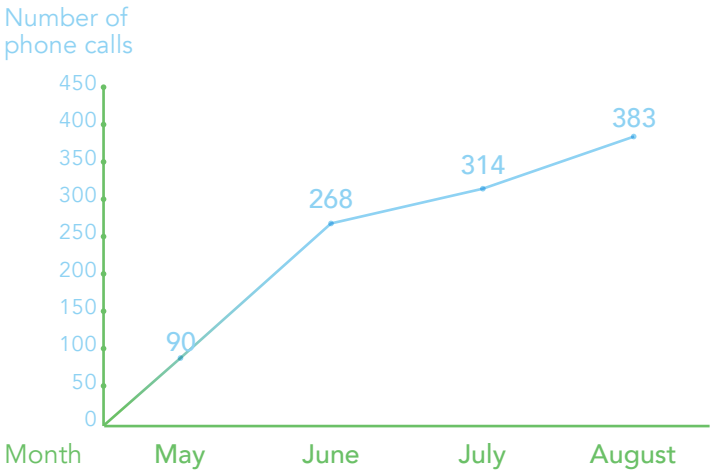
Disruptions caused by the pandemic to mental health services for vulnerable populations globally

2. IMPACT OF THE PANDEMIC IN HONDURAS

As in the rest of the world, in Honduras the COVID-19 pandemic has exacerbated the enormous challenge of mental health and has forced us to understand its importance. However, mental health remains stigmatized and is not seen as a priority. The pandemic context illustrates the close link with people's physical health and the urgent need to address the structural challenges that prevent the recognition and importance that mental health deserves.

Aware of the profound impact of the pandemic and the existing gaps, MSF has worked in Tegucigalpa since May 2021 providing psychological care services via phone calls to people affected with symptoms associated with the COVID-19 pandemic and their family members.

TOTAL CARE PROVIDED PER MONTH

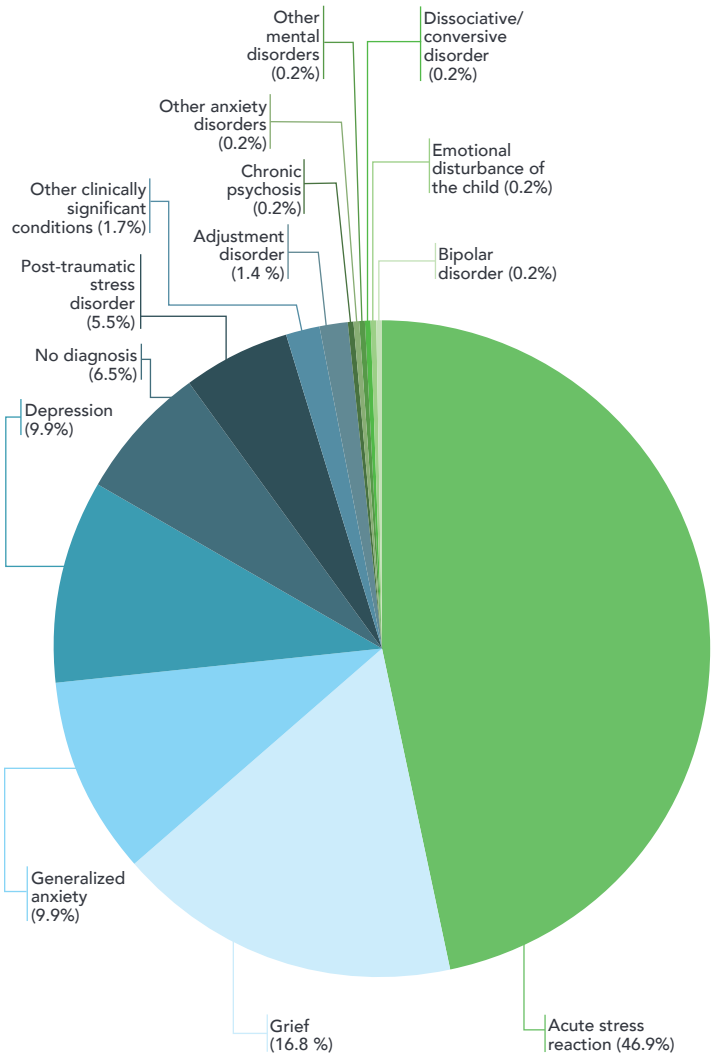


During the specific period from May to August 2021, a total of 1,055 telephone calls were recorded. Of this total, 75% of the calls corresponded to female patients and the prevalent diagnoses identified were: acute stress reaction (44%), grief process (16%), generalized anxiety (13%), depression (10%) and post-traumatic stress disorder (5%). [18]

Similarly, it has been observed that the main precipitating and risk factors faced by the population are: being infected with COVID-19 (68%), induced by stigmatization (guilt, rejection by others) and fear of dying. The second precipitating factor was the death of a family member (57%), followed by having a family member with a severe medical illness (24%).

During their telephone consultations at the COVID-19 care center, MSF psychologists accompany patients and their families when dealing with the grieving process and bad news.

MENTAL HEALTH DIAGNOSES OF THE CONSEQUENCES OF THE PANDEMIC.
SOURCE: MSF - PROJECT COVID-19 TEGUCIGALPA MAY - AUGUST 2021



COVID-19 AND MENTAL HEALTH - TESTIMONY OF A PSYCHOLOGIST - TEGUCIGALPA

During an initial screening tele-consultation with a 54-year-old woman, the patient told me that on June 11 of this year [2021] two of her sisters became infected in the hospital while caring for their mother. Later, her two children were also infected.

'My older sister then infected me. I had a fever and was put on oxygen immediately. My son called the hospital so that they would take my cell phone away and I would not hear the news. When I got home, I asked for the phone and my son would not give it to me, he told me it was in storage, that he would give it to me later. On Saturday, July 3, they took me to my sisters' house and told me: "My mommy is no longer here...". I felt like I was dying'.

What struck me most was the experience that a family can have, knowing that their relatives can have so many medical diagnoses and bad news at the same time, and, above all, how access to all the information becomes limited. At the end of the therapies, the patient shared with me that, as a result of the process she started, she was able to balance her mood, she returned to the activities she was doing before her crisis, she was able to reduce her levels of worry and she was able to recognize which emotions she was experiencing and how she could control them. I consider it an achievement that she has accepted her loss and stabilized her emotions and, above all, that she has changed her perspective on death.

Identifying information has been changed to protect patient confidentiality.

18 MSF Project COVID-19 HN155

III. PROPOSALS TO REDUCE THE GAP ON MENTAL HEALTH

To get an understanding of the magnitude of mental health needs, the following chart illustrates the major disorders worldwide:

Mental disorders worldwide (2017) [19]

Any mental health disorder:
10.7% (792 million)
9.3% men
11.9% women

Depression:
3.4% (264 million)
2.7% men
4.1% women

Anxiety disorders
3.8% (284 million)
2.8% men
4.7% women

Bipolar disorder:
0.6% (46 million)
0.55% men
0.65% women

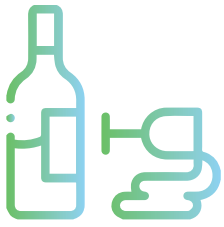
Eating disorders (clinical anorexia and bulimia):
0.2% (16 million)
0.13% men
0.29% women

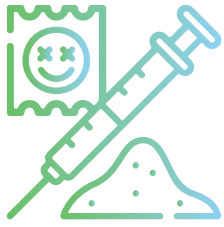
Schizophrenia:
0.3% (20 million)
0.26% men
0.25% women

Any mental or substance use disorder:
13% (970 million)
12.6% men
13.3% women

Alcohol use disorder:
1.4% (107 million)
2% men
0.8% women

Drug use disorder (not including alcohol):
0.9% (71 million)
1.3% men
0.6% women





19 Dattani, S., Ritchie, H. & Roser, M. (2021). *Mental Health*. Available at: https://ourworldindata.org/mental-health#data-availability-on-mental-health

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The mental health gap exists in all countries of the world, but the size of the gap significantly varies from one country to another. The mental health gap can be assessed by considering the need for service and the provision of mental services.

Depression continues to occupy the leading position among mental disorders worldwide. It is estimated that 264 million people suffer from depression and it is almost twice as common in women as in men. This is partially explained by the fact that during pregnancy, between 10% and 15% of women in industrialized countries suffer from depression, and between 20% and 40% in developing countries.[20]

Mental and neurological disorders in older adults (Alzheimer's disease, other dementias, depression) contribute significantly to the burden of noncommunicable diseases. Globally, it is estimated that up to 55 million older adults suffer from some form of dementia, increasing annually by 10 million. In the Americas, the prevalence of dementia in people over 60 years of age ranges from 6.46% to 8.48%. Projections indicate that the number of people with this disorder will double every 20 years.[21]

The mental health treatment gap for some of the more specific disorders is estimated as follows: severe and moderate adult substance use and anxiety disorders, 73.5% in the Region of the Americas, 47.2% in North America, and 77.9% in Latin America and the Caribbean. The gap for schizophrenia in the Latin American region is 56.9%, for depression it is 73.9% and for alcohol it is 85.1%. Despite the social burden that some of these disorders represent, as well as the wide gaps at regional level, the median public expenditure on mental health in the entire region represents only 2.0% of the health budget, and more than 60% of this money is allocated to psychiatric hospitals. [22]

To address the access to mental health care gap in resource-poor countries, MSF suggests a comprehensive approach that includes increasing the overall budget for mental health care, developing national mental health policies and plans, restructuring mental health services, and implementing practical strategies such as the mhGAP program.

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20 Dattani, S., Ritchie, H. & Roser, M. (2021). *Mental Health*. Available at: https://ourworldindata.org/mental-health#data-availability-on-mental-health

21 World Health Organization (2021). *Dementia factsheet*. Available at: https://www.who.int/news-room/fact-sheets/detail/dementia

22 WHO (*s.f.*) Mental health. Available at: https://www.paho.org/es/temas/salud-mental

1. WHAT IS THE MHGAP PROGRAM?

In October 2008, WHO presented the Mental Health Gap Action Program (mhGAP).[23] The objective of this program is to facilitate interventions by non-psychiatric personnel for the prevention and treatment of mental disorders. This same program has proven its effectiveness in improving access and scaling up interventions, as well as its ease of implementation in low- and middle-income countries. Priority disorders that the program can treat include: depression, psychosis, self-injury and suicide, epilepsy, dementia, and substance use disorders.

To facilitate its implementation, an Intervention Guide (mhGAP-IG) was produced, which is a resource for both specialized and non-specialized medical professionals that enables the application of the mhGAP guidelines. This provides guidance and tools for the assessment and integrated management of common forms of priority disorders. This guide is currently in its second edition. MSF also implements it in various operations around the world.

The program has a phased approach, allowing for a progressive implementation of mental health services. For example, in the first stage it aims to strengthen the capacity of a wide range of health professionals; in a second stage, through a reference guide, health professional programs can be developed and updated; and in a third stage, the components can be implemented at the community level.

Studies describing the implementation of mhGAP-IG through training and supervision in low- and middle-income countries have shown a significant increase in accessibility to health services, as well as the reduction of internal barriers by generalist health care providers. In this regard, the trainings have provided improved knowledge, attitudes, and confidence. In addition, it has been found that those who have benefited from the training have shown a greater commitment to patient care.[24]

23 PAHO (2017). *mhGAP intervention guideline for mental, neurological and substance use disorders at the non-specialty level of care. Version 2.0.* Available at: https://iris.paho.org/handle/10665.2/34071

24 Keynejad R, Spagnolo J, Thornicroft (2021). *GIWHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact Evidence-Based Mental Health 2021.* 24:124-130

For its implementation and expansion, PAHO/WHO provides technical support to most countries in Latin America and the Caribbean. This includes the development of national mental health policies and plans and the restructuring of mental health services. However, for this program to perform well, sufficient, and sustainable resources must be allocated. In other words, a good implementation of the mhGAP program requires investments both to comply with the provision of adapted care spaces, as well as human resources and adapted medications.

2. HOW CAN WE NARROW THE GAP ON MENTAL HEALTH?

Lack of psychiatrists and psychologists incorporated into public health services is a major cause of the mental health gap. Meanwhile, the total number of people with mental illness who do not receive any professional care is increasing.

As mentioned above, the main recommendation to reduce the gap is the investment in resources for policy-supported structures and trained personnel, both specialists and non-specialists.

To address the most urgent needs, MSF suggests a range of strategies, several of which are implemented by the organization itself. Among the strategies employed are interventions based on the Mental Health and Psychosocial Support (MHPSS) Guidelines. This strategy aims to prevent, care for, and promote the mental health and psychosocial well-being of individuals and communities affected by all types of personal and contextual situations that may impact their mental health. This vision is different from the traditional model of psychological care, as it seeks to take advantage of the resources and capacities available in the communities, and thus offer care to the population according to the specific context.

MSF also supports the implementation of the mhGAP program in the structures in which it intervenes. Implementation support includes training and supervision of health professionals to ensure the sustainability and recognition of mental health services, always with a view to going beyond the health center: the community itself.

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The mhGAP intervention strategy begins with a community approach, which consists of the important work of mental health promotion and prevention, and the provision of support to people with mental health problems from local institutions, such as associations, schools, workplaces and homes.[25] The WHO Community Toolbox has a detailed description for the implementation of this first component.

The second component consists of interventions in primary health centers or the hospital sector with specialized care, where psychological and medical care is provided with recourse to pharmacological treatments. It is in these spaces where the care of specialized and non-specialized mental health professionals trained through the WHO mhGAP-IG 2.0 guide is applied. In addition to training, key aspects to ensure the sustainability in quality of these interventions include regular evaluations and follow-ups, as the process of implementation and response to the population progresses, and access to medication at the primary health care level. Access to medicines translates into the inclusion of medicines in the facilities' inventory and ensuring that there are no gaps in access to these medicines.

Other strategies include strengthening future resources by integrating more robust mental health components into the training process early on, as well as facilitating internships for students. Currently, MSF is seeking to establish a collaboration between universities and SESAL so that final year psychology students can carry out their internships in health centers and hospitals. This would allow SESAL to have a

25 WHO (2019). *The mhGAP Community Toolkit: field test version.* Available at: https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version

sustainable system of mental health professionals at the primary and hospital levels of priority attention in Tegucigalpa, San Pedro Sula and Choloma. It would also help meet the demand, create spaces for promotion and prepare future generations. An important challenge to consider is the system of monitoring, accompaniment, and evaluation of the quality of the work of these practitioners.

There are also several recommendations and best practices for facilitating and implementing specific programs such as mhGAP, which emerge from the experience of other public institutions, implementing partners and practitioners around the world.

MSF has compiled a number of these recommendations and best practices that may be of interest to the Honduran case. For example, it has been noted that some of the challenges arise directly from patients, specialized staff, non-specialized staff, health facility authorities, the communities, and the governments themselves.[26] This is why MSF recommends integrating all actors in the design of strategies from the very beginning. Similarly, WHO points out that the challenge for all actors to reduce the gaps requires greater political will, public investment, awareness of health personnel, involvement of families and communities, and collaboration between governments, international organizations and other stakeholders.[27] In other words, partnerships and collaboration among the various actors are essential.

In this regard, MSF expresses interest and availability to support the process of design, preparation, training, and accompaniment in the development of institutional capacities.

26 Hernández Muñoz, V. (2021). *Main challenges and best practices in the implementation of mhGAP in México and Central América. A Narrative Review of the literature*. Mailman School of Public Health, Columbia University - Médecins Sans Frontières

27 WHO (2008). *mhGAP: Mental Health Gap Action Program: Improving and Expanding Care for Mental, Neurological and Substance Use Disorders and expansion of care for mental, neurological and substance abuse disorders.*

MHGAP CASE - TESTIMONY OF A PSYCHOLOGIST - TEGUCIGALPA

One afternoon in May, while I was organizing some files in the archive, there was a knock at the door of our clinic. As I went to answer the knock, I caught sight of a young woman. The tone of her voice was one of desperation and fear as she asked, "Is this the Médecins Sans Frontières clinic? I immediately opened the door and asked her come into my office, where she took a seat and after introducing myself and telling her how confidential and free our services were, she burst into tears and painfully told me her story of sexual aggression, as the result of a chain of violent events, initiated by a threat her husband received a few months ago.

The feeling of guilt invaded her, she repeated: "I should have gone with him... I am desperate... I don't know what to do". At that time she was given medical and psychological care and we continued with follow-up care. Since the symptoms did not diminish through psychotherapy, together with the doctor, supervised by a psychiatrist through the MSF telemedicine platform, it was indicated to start medical treatment with the use of Fluoxetine. After some consultations, she presented considerable improvement.

She expressed gratitude and how much it helped her to come to our attention. Unfortunately, the chain of violent events continued with further sexual assaults. As difficult as it is to experience these events, it is comforting for me to know that she feels confident to return for help. It is also amazing how resilient she is despite the difficult days. She has been able to sleep again, feels less nervous, no longer feels so sad and is able to enjoy some activities outside of her home in the company of her loved ones.

Today, she tells me that the memories come less and less frequently, and she always repeats to herself: "I can't give up, I do everything I can to be well".

Identifying information has been changed to protect patient confidentiality.

CONCLUSION

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While the entire region continues to be burdened by mental health gaps, Honduras faces the significant challenge of addressing mental health needs in a context that constantly generates direct consequences on its population. This context, marked by poverty, violence, and the impacts of extreme weather, now faces, like the rest of the world, a pandemic applying further pressure on a national health system with minimal existing resources. Vulnerabilities associated with mental health needs do not cease, and responses, despite the challenges faced, can find solutions and adapted alternatives, such as those shared in this report.

Today there are many strategies that seek to address the complex and urgent needs for access to mental health services. Some of them have been described in this report, encouraging the mobilization of government agencies and partners to response directly and the integral development of the State's capacities to reduce the existing gaps. Collaboration will require all coordinated actions and political support to materialize comprehensive care for the most needy and vulnerable population.

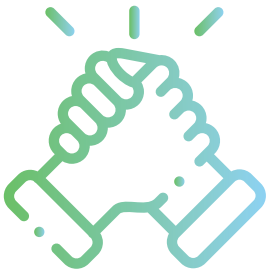
It is therefore hoped that the recommendations expressed here will accelerate the evolution of regulatory frameworks and practices for decentralization of psychiatric and mental health care services, as well as the allocation of more resources to alleviate this national challenge.

RECOMMENDATIONS

1

Establish long-term commitments, supported by public policies, to ensure the sustainability of health care programs

2



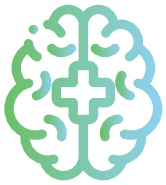
To continue joining efforts among the various actors involved to provide quality mental health care and to encourage promotion, prevention, and access programs, particularly at the community level for vulnerable populations

3

Promote the integration of mental health in a cross-cutting manner in all health services, using strategies such as the mhGAP program to strengthen public services

4

Open decentralized care spaces, offering technical support to mental health professionals



5

Increase the investment of human and financial resources specifically dedicated to mental health services outside specialized institutions

6

Ensure the availability of psychotropic medications required for the implementation of the mhGAP program

MENTAL HEALTH IN HONDURAS