

An Intervention Special Issue

Integrating mental health care into existing systems of health care: during and after complex humanitarian emergencies

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Complex humanitarian emergencies, whether arising from armed conflict or natural disaster, challenge the mental health system of a country in many ways. Not least because they increase the risk of mental disorder in the population, and undermine the pre-existing structures of care. They may, however, also bring new opportunities to create change. In this way, new structures and paradigms may emerge from the midst of a crisis. The probabilities for such a change to occur vary from one setting to another. Regardless, it has been seen that interventions in complex humanitarian emergencies should not be limited to the deployment of specialised resources that will disappear once the emergency has lost its urgency, or visibility. Apart from provision of direct services, interventions in these circumstances should also aim to build local capacity and install sustainable systems of mental health care at the time of the intervention. This paper serves as an introduction to this special issue of 'Intervention' and examines the various aspects surrounding integration of mental health care and psychosocial support into overall health systems during, or after, complex humanitarian emergencies.

Keywords: capacity building, complex humanitarian emergencies, documentation, mental health care, sustainability

Complex humanitarian emergencies: context

A disaster is the result of a vast ecological breakdown between a population and the environment, on such a vast scale that the demands exceed available resources (Gunn, 2003). The disaster situation overwhelms the response capacity of the affected community and causes disruption and disintegration of the social fabric by prohibiting the survivors from functioning normally (Pérez-Sales, 2004). Traditionally, disasters are categorised as either natural disasters (such as earthquakes or floods) or man-made disasters (such as technological disasters, environmental disasters, terrorist acts, armed conflicts or refugee crises). However, this historical dichotomy is losing its utility. For example, the impact of 'natural' disasters is often compounded when occurring in already fragile ecological or political contexts, while armed conflicts and massive displacements are, in turn, fuelled by ecological factors such as population pressure, and struggles for control over scarce natural resources such as fertile land and water. Many disasters do not have a single cause. The 2010 earthquake in Haiti occurred in a context characterised by social inequalities,

grossly inefficient public services and ill prepared physical infrastructures. As a result, the earthquake had a much more devastating impact than it would have had in a politically stable, high income country with fully functional public services. For these situations, the term *complex humanitarian emergency* was coined, specifically to describe settings in which multiple, often historically and politically determined, aetiological factors both predispose an area to disaster, and mitigate its outcomes. Complex humanitarian emergencies are often characterised by factors such as: dislocation of populations, destruction of social networks and ecosystems, insecurity affecting civilians and others not engaged in fighting, and abuses of human rights (Leaning, Briggs, & Chen, 1999). In such multidimensional disasters, natural and man-made factors are closely intertwined. High levels of violence and social insecurity, in particular, threaten the capacity of the population to sustain livelihood and life (Zwi & Ugalde, 1991).

Complex humanitarian emergencies: three phases of assistance

The conventional classification for the sequence of humanitarian assistance uses three phases: relief, rehabilitation and development. Activities included in the *relief phase* aim to provide essential services to those whose survival is threatened. This phase is followed by *rehabilitation*, in which basic services such as schools, health care, and water supply are restored, and damaged infrastructure is rebuilt. Finally, the assistance can focus on broader goals, such as economic growth, improving living standards and creation of wealth and social capital (Ryscavage, 2003). While this relief–rehabilitation–development continuum is

meant to organise the post disaster response in a logical way, there are fundamental flaws with it in complex humanitarian emergencies. For example, this continuum tends to obscure the social, macro-economic and environmental factors contributing to the disaster in these settings, and it may serve to legitimate restoration of a socially and morally unjust, fragile status quo.

Documents that provide consensus frameworks to guide humanitarian responses after disasters, emphasise community based approaches and the need to reinforce the responses of the local population (IASC, 2007; The Sphere Project, 2011). Typically, these frameworks limit their scope to the responses occurring *in the midst of an emergency*, generally the first months after a disaster. Within one to two years after an emergency, many organisations have ended their programmes and moved to new emergency settings. The changing nature of humanitarian emergencies, however, from short term emergencies in confined areas to prolonged emergencies in large geographical areas, need a different approach, with due attention given to capacity building of national staff and public institutions (Salama et al., 2004). In this post disaster phase, the need for new leaders and unconventional approaches may arise. This can call into question the status quo of *‘how things were always done’*, and may lead to rethinking and redefining public service delivery. The influx of local and foreign qualified professionals, and the provision of aid funds, can provide additional factors to create opportunities for change, if the opportunities are seized at the right moment. This requires the use of long term perspectives that go beyond immediate services delivery, and aim to restore and restructure the systems that provide these services (deJong, 2002).

Mental health and psychosocial support in complex humanitarian emergencies

Attention to mental health and psychosocial support (MHPSS) in the aftermath of disasters is relatively new, and has led to fierce and often polarised debates about what kind of mental health care and psychosocial support needs to be organised (Ager, Strang & Wessells, 2006; Galappatti, 2003; van Ommeren, Morris, & Saxena, 2006; Williamson & Robinson, 2006). The widely diverging views among MHPSS practitioners working in complex humanitarian emergencies contributed heavily to poor coordination across approaches, resulting in fragmented services and a lack of comprehensive support. The wide range of opinions about what should be done is partly related to the absence of a solid base of evidence on the results of MHPSS interventions in complex humanitarian emergencies (Wessells & van Ommeren, 2008). The need to create such an evidence base is obvious (Tol et al., 2011), yet too often, intervention strategies are employed where the effectiveness is not at all clear. It is also, as yet, unclear how emergency MHPSS may contribute to lasting mental health reforms in the post disaster/post conflict phases, and whether the efforts during emergencies actually do lead to an improved mental health care delivery for the population (Allden et al., 2009). MHPSS service providers in complex humanitarian emergencies can learn from experiences elsewhere in the developing world, and, in turn, may provide data that are useful for the emerging global mental health movement.

Mental health, an emerging global priority

Mental health is becoming a global health priority because of the relative high

prevalence of mental disorders and the associated disability (Prince et al., 2007). Among the most prevalent mental disorders are: depression, schizophrenia and alcohol or drug abuse disorders (World Health Organization, 2005). While non-communicable diseases, including mental disorders, already pose a substantial global economic burden, this burden is expected to rise more than double in the next two decades. Within this group of noncommunicable disorders, the most important contributors to the global economic burden are mental health conditions and cardiovascular disease (Bloom et al., 2011). In low income countries, the resources for mental health care are very limited, typically less than 1% of an already low health care budget (Saxena et al., 2007). Although there has been a lobby to promote mental health care in the development agenda in low income countries, there are also major challenges about *how* to integrate mental health care into health sector reform plans. Some of these challenges include: engaging mental health professionals in general health sector reforms; strengthening the links between mental health and social development; and intensifying resource mobilisation (Jenkins et al., 2010). One key to improving mental health in communities is to look beyond narrowly defined health care systems. Treatment of mental disorders requires more than just individual therapies for the sufferers. They should also foster the inclusion of mental health interventions into general health systems, thereby strengthening policies (Jenkins et al., 2011), as well as foster integration of mental health aspects in general social policies to improve the wellbeing of the population (Friedli, 2009). A recent consensus seeking exercise among hundreds of researchers, advocates and clinicians, identified the most urgent research priorities

for improving the lives of people with mental illness around the world. The five most important areas to be researched are related to: 1) strengthening the mental health component in the training of all health care personnel, 2) integrating screening and core packages of services into routine primary health care, 3) reducing the cost and improving the supply of effective medications, 4) providing effective and affordable community based care and rehabilitation, and 5) improving children's access to evidence based care by trained health providers in low and middle income countries (Collins et al., 2011).

One of the main strategies to improve access of the population to mental health services is to integrate such services within the general health care system, and to avoid stand-alone systems based on specialised psychiatric hospitals. Integrating mental health services into primary health care (PHC) is often considered the most viable way of ensuring that people get the mental health care they need (World Health Organization & Wonca, 2008). Primary health care is defined as the first level of health system contact with the population. It includes various aspects, such as: health promotion, prevention, care for common illnesses, and management of on-going chronic health problems. Primary health services act as the principal point of consultation for patients within a health care system, and depending on the conditions of the system in the area, and the type of structure, it can be carried out by a doctor, nurse, midwife, community health worker, traditional healer, or members of the group or the community. There is no single best practice model for the integration of mental health care into PHC that fits all contexts. In documenting 11 examples of successful integration of mental health care into

primary care, only one country, Uganda, was a post conflict or post emergency setting (World Health Organization & Wonca, 2008). Among the basic requirements to make the integration a success are elements such as adapting mental health policies, ensuring that primary care workers are adequately trained, organising appropriate supervision, ensuring that primary care workers are not burdened with unrealistic amounts of tasks, and making specialist mental health care professionals and facilities available to support primary care. One important practical lesson was the need to collaborate with other government non health sectors, nongovernmental organisations (NGOs) and community networks.

The World Health Organization has launched the comprehensive mental health Gap Action Programme (mhGAP) to address this lack of care, especially in low and middle income countries, for people suffering from mental, neurological and substance use disorders. This includes an intervention guide with evidence based mental health interventions for general health workers (World Health Organization, 2010). There is now an urgent need to use these available tools on a larger scale, and to document what we can learn from the process to scale up mental health services in low resource settings (Eaton et al., 2011).

A closer look at mental health interventions in emergencies: what should be done?

There is an important and large gap between the rapidly increasing knowledge base on community mental health care in low and middle income countries, and the mental health and psychosocial work that is actually done in emergencies (Alllden et al., 2009). One important challenge in planning

mental health services in complex emergencies is how to ensure that the service has immediate, measurable benefits, while at the same time building a model that is sustainable and ultimately integrated within the broader primary health service (Silove, 2004b). The World Health Organization advocates strengthening pre-existing mental health services. Particularly after the most acute distress has decreased, and the most basic needs have been addressed, efforts should be directed towards establishing a more comprehensive range of community based mental health interventions, ensuring that 1) people with severe mental disorders (e.g. psychosis, severe depression) have access to effective care in the community, 2) mental health care is available within general health settings and 3) links to outside the formal health sector are established and made functional. This last point could include, for example, training and supervising of social workers, teachers, community leaders, and, when feasible, and traditional healers (van Ommeren, Saraceno, & Saxena, 2004).

Many papers published on mental health problems in humanitarian emergencies focus on the prevalence of mental disorders, with a strong emphasis on posttraumatic stress disorder (PTSD) and depression. Reported prevalence figures of depression and PTSD vary widely between surveys of conflict affected populations. While this may be a result of contextual factors, such as the extent of exposure to adversity, they are also strongly affected by methodological differences (Rodin & van Ommeren, 2009). Trauma focused surveys are also often unable to identify the effects of a complex emergency on a population's ability to care for itself (Ager, 2002), or to identify locally used cultural expressions

on the lack of wellbeing (Miller, Kulkarni, & Kushner, 2006). Prevalence rates of severe mental disorders, such as psychosis and bipolar disorder, are largely unknown. A rough estimation is that a humanitarian crisis leads to an increase of the prevalence of severe mental disorders from 2–3% to 3–4% in the first 12 months, and for common mental disorders from an estimated 10% at baseline (pre-crisis) to 20% (van Ommeren, Saxena, & Saraceno, 2005). In striking contrast to the impressive amount of scientific papers on prevalence figures in complex emergencies, is the dearth of papers describing the outcome of actual interventions to tackle such problems. The published literature is skewed towards psychological interventions for PTSD. This emphasis on trauma related mental problems is not consistent with the kind of programmes that are usually implemented, and for which there is an urgent need to assess the effectiveness. MHPSS interventions initiated by external actors, such as international NGOs, frequently are not well connected to existing systems of care. A recent survey of 160 reports of actual interventions found that the vast majority of them took place and were funded outside existing systems of care, such as national mental health care systems (Tol et al., 2011). A World Bank report in 2005 identified this lack of systematic documentation of mental health and psychosocial interventions in post emergency and post conflict settings as the major obstacle to more effective and better targeted interventions (Baingana, Bannon, & Thomas, 2005). Others have called for a public discussion on the results of assessments and evaluations of mental health activities in complex humanitarian emergencies, so that lessons can be learnt for future interventions (Mollica et al., 2004).

How trying to help can make things worse: the example of Sri Lanka

In the aftermath of some humanitarian emergencies, the influx of organisations and groups providing all kinds of assistance can be quite overwhelming. More to the point, they may also inadvertently undermine existing assistance structures, and discredit local ways of coping with adversity. This has been poignantly described in post tsunami Sri Lanka, where delivering of mental health care and psychosocial support in affected areas was compromised by the massive destruction of infrastructure, and difficulties coordinating responses between many organisations were involved (Ashraf, 2005). A Sri Lankan psychiatrist, Ganesan (2006), saw dozens of experts in mental health and psychosocial support being *'parachuted'* in to the east coast of Sri Lanka to start a multitude of trauma- focussed activities, while there was far less attention given to much more urgent social work projects and programmes to care for those with severe mental disorders such as psychosis. In his chapter *'The wave that brought PTSD to Sri Lanka'*, Watters (2010) provides disconcerting examples of the rather toxic combination of cultural naiveté and the therapeutic arrogance of many of these experts. Humanitarian interventions, such as mental health training of local staff, may amount to the imposition of western concepts of distress and disorder, to populations with different ways of understanding human suffering (Abramowitz, 2010). Moreover, the efforts of outsiders to provide mental health assistance tends to obscure the efforts by local stakeholders (Fernando, Pedersen, & Weerackody, 2010). There is also a risk that NGO programmes take away mental health professionals from the public system. As Ganesan (2011) mentions in this

issue, he was the only psychiatrist in the heaviest affected area of Sri Lanka post tsunami, and felt pressured by external agencies and the media to decrease the time he spent treating people with severe mental disorders, and to favour trauma focused interventions of the newly started programmes instead.

How something good may come out of a disaster: the example of Sri Lanka

Fortunately, there are also good examples where mental health interventions in the setting of complex humanitarian emergencies have had long lasting, positive effects on mental health service delivery. Again, Sri Lanka may serve as an example. The financial aid generated as a response to the tsunami boosted the development of community centred, and therefore decentralised, mental health care in Sri Lanka. For example, in the northern town of Jaffna, local organisations and authorities formed a joint Mental Health Task Force in the first months after the disaster, in order to coordinate their activities (van der Veen & Somasundaram, 2006). The ad hoc task force was later transformed into a formal intrasectoral, coordinating body for local governmental and NGOs involved in mental health and psychosocial work, and continued to be a driving force for improving MHPSS services in the area (Krishnakumar, Sivayokan, & Somasundaram, 2008). Prior to the tsunami, in the north-eastern areas of Sri Lanka, there was a long history of protracted armed conflict. There, local mental health workers had already started innovative mental health services within secondary and primary care. The World Health Organization advised using this model for other districts in Sri Lanka (Sarceno & van Ommeren, 2003). Unfortunately,

donors were initially uninterested, that is until the 2004 Asian tsunami. The sudden availability of funds for mental health care prompted the development of a national mental health policy that encouraged decentralisation of service, and that was *de facto* based on the innovative work developed in the conflict affected areas in the north east (Saraceno, 2005). The increased awareness of the importance of mental health care after the tsunami, prompted the establishment of decentralised mental health services integrated into general health care, and led to training of general health workers to provide treatment for people with mental health problems in the tsunami affected areas (Mahoney et al., 2006). Several years after the tsunami, there are still mental health services in seven tsunami affected districts of Sri Lanka, run by the Ministry of Health (WHO, 2008). A map of the diversity and spread of mental health services shows the improvements quite dramatically (*Figure 1*).

The importance of documenting experiences

The brief examples of Sri Lanka above may serve to highlight the importance of describing the process of how interventions in these settings, often starting with a relief perspective, can lead to more fundamental changes in mental health service delivery. Perhaps there are many experiences of mental health care being integrated into existing systems of care during humanitarian emergencies, but to our knowledge, they are rarely documented. Edited volumes on mental health in post war and post conflict settings pay limited attention to aspects related to the integration of mental health care into existing systems, and focus

instead on the development of NGO based services. Or they describe the immediate mental health response without taking a longer term perspective, while in turn, books on mental health care development in resource poor settings often do not address the specific context of humanitarian emergencies.

There are many reports of successful mental health training of general health workers in humanitarian settings (Budosan, 2011; Budosan et al., 2007; Henderson et al., 2006; Mohit et al., 1999; Sadik et al., 2011; Ventevogel & Kortmann, 2004). These articles usually describe how it was feasible to install basic mental health care skills in general health workers. However, we are left with the question of what happened after? Some articles describe how attempts to start primary mental health services within primary care proved feasible within the project period, showing clear increases of numbers of patients receiving treatment (Budosan & Jones, 2009; Jones et al., 2007a; Jones et al., 2009; Somasundaram et al., 1999; Souza, Yasuda, & Cristofani, 2009). Yet, most of these publications focus on direct output (building mental health skills in staff, increasing the number of patients in treatment) with less attention to a systematic description of *how* these interventions could contribute to long lasting changes in public mental health services delivery. It is rare to find published documentation on how mental health projects, that started in the aftermath of a humanitarian emergency, moved from a project with an initial focus on relieving immediate suffering to long term programmes to strengthen mental health care services. There are exceptions. In the 1980s in Guinea-Bissau, then recovering from an 18 year long war of independence, a community mental health programme was set

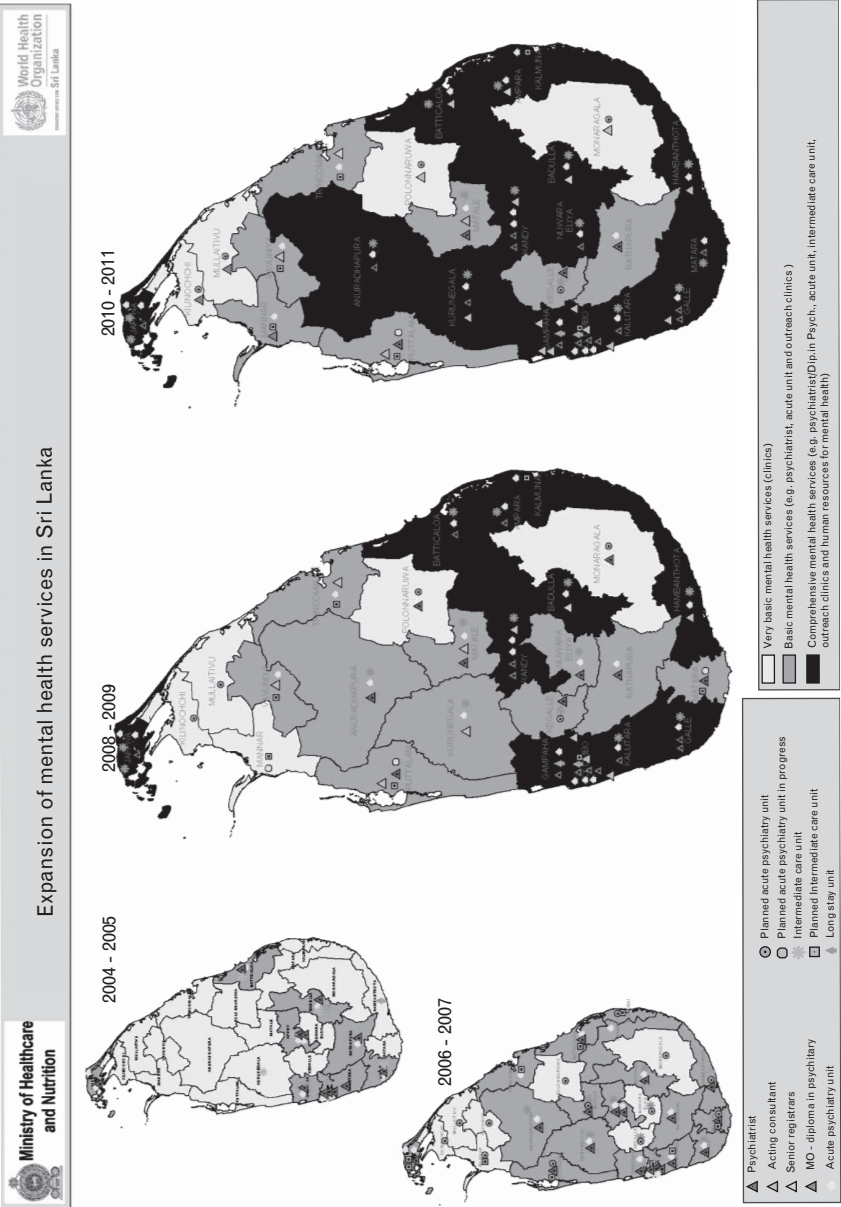


Figure 1: Map of Sri Lanka showing the development of mental health services, 2004–2011. (Source: Ministry of Health & Nutrition and World Health Organization Sri Lanka.)

up to train primary health care workers in mental health, and the evolution of this programme was described for a period covering more than a decade (de Jong, 1996). In Timor Leste, overwhelmed by the effects of mass violence, displacement and destruction of infrastructure after its violent cessation from Indonesia in 1999, a mental health care programme with a strong community oriented outlook was described for a period covering more than a decade (Silove et al., 2011). In Afghanistan, after the fall of the Taliban in 2001, NGO led mental health projects started with the aim of integrating mental health into existing governmental health care services. Several NGOs and the WHO contributed to curriculum development and advocacy for the inclusion of mental health into the Basic Package of Health Services (Ventevogel, Faiz & van Mierlo, 2011). There are however many more complex humanitarian emergencies in which governments, local organisations and international NGO design and implement mental health programmes. Unfortunately, little is known about these experiences. For example, in Aceh, the emergency programme by an international NGO after the 2004 tsunami (Jones et al., 2007) was later taken over by another international NGO with a strong focus on development. The health authorities made annual budgetary allocation to continue the primary health centre based community mental health services, but this experience has not yet been documented (A. Mohanraj, personal communication). Much of the experience of organisations that actually make the transition from emergency relief to the adoption and promotion of structural changes in service delivery for people with mental disorders, remain undocumented to this day.

Emergencies: risks and opportunities for strengthening existing mental health care systems

Complex humanitarian emergencies create both enormous challenges and opportunities for structural improvement of mental health services. A discursive reading of the published literature led us to identify the following opportunities and challenges for the development of sustainable mental health services, during and after complex humanitarian emergencies:

Risks

1. Creating parallel systems

The breakdown of often already weak and inefficient public services often prompts aid organisations to start services by themselves. While there may not always be an alternative, the risk is that unsustainable programmes are created, with the result that instead of supporting the public system, it may undermine it. Interventions may focus on one particular type of '*mental disorder*', while ignoring that the spectrum of mental health problems in complex emergencies is much broader (Summerfield, 1999). If separate services are started, it is often challenging NGOs to make the transition towards integrated, horizontal programming (de Jong, 2007).

2. Interventions by outsiders may ignore what people do themselves

Humanitarian interventions may silence, or marginalise, local perspectives and local views (Abramowitz & Kleinman, 2008). The acceptable, or dominant form of healing communities after mass upheaval, is expected to come from humanitarian aid and this tends to obscure the *healing the social wounds of war*.

In other words, how communities themselves mobilise their own social, and other resources, in order to recover in their own time and in their own way (Last, 2000).

3. *Medicalising non pathological distress and social problems*

The World Health Organization warns of the risk of misapplication of the medical model by general health workers with basic training in mental health care (van Ommeren et al., 2004). This has been documented as a real problem in complex humanitarian emergencies, such as Afghanistan (Ventevogel, Faiz, & van Mierlo, 2011).

4. *Overburdening general health workers with skills and knowledge they cannot use*

General health workers in overloaded health care facilities have limited time for each encounter, and often do not have the time to go deeper into the presented complaints and therefore miss mental health disorders that present as physical problems (Afana et al., 2002).

5. *Providing insufficient supervision and follow up training*

Systematic supervision and training, preferably attached to existing institutions, is an essential ingredient of capacity building, but may also be given limited attention in practice (Silove, 2004a).

Many of these risks are not specific to the situation of complex humanitarian emergencies, but may become more pronounced and urgent in such emergencies. Similarly, the unusual context of complex humanitarian emergencies can also provide opportunities that, again, may not be specific for these contexts, but may be more pronounced.

Opportunities

1. *Increased funding opportunities*

Some complex humanitarian emergencies, particularly those involving acute natural disasters such as earthquakes or tsunamis, may generate many millions of dollars in emergency relief. This is usually distributed by multilateral agencies and foreign governments, and translated into short term projects by international NGOs. The unprecedented amount of funding, in an otherwise disadvantaged or marginalised region, can provide opportunities to start new initiatives that boost mental health care.

2. *Possibilities to involve different categories of health workers in mental health activities*

The massive needs arising in emergencies may lead health authorities to accept piloting new initiatives for mental health care provision, including the training of general health workers, the use of paramedical staff and working closely with communities. Mental health care should be linked with other sectors, outside the health care system in order to become effective on a community level (World Health Organization, 2003). Perhaps the most powerful interventions to improve the mental health status of people in impoverished circumstances are outside the formal health sector. Interventions dealing with mental health can play an important role in effective post conflict reconciliation and reconstruction (Baingana, Bannon, & Thomas, 2005). The influx of organisations with community focused orientations may make help to improve such inter-sectoral links.

3. *Including mental health care in health sector reforms*

Mental health care should not be isolated from other parts of health care.

It needs to be linked with other, more general approaches to strengthen the health care sector, including aspects such as general health sector reform and results based financing. Emergencies often lead to health sector reforms, and in several post conflict settings, such as Afghanistan, Somalia and Liberia, this has led to the incorporation of mental health into minimum packages of care (Ventevogel et al., 2002). Health policy makers are also more likely to accept and implement mental health care reforms (Munir et al., 2004; Pandu Setiawan & Viora, 2006)

This *Special Issue* of *Intervention* documents a variety of examples from mental health programmes in the aftermath of natural disasters and armed conflict. Some of the main lessons learned are described in the closing article of this issue (Pérez-Sales et al., 2011). We hope it will contribute to building an evidence base for integrating mental health care into existing systems of health care, in complex humanitarian emergencies.

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Integrating mental health into primary health care settings after an emergency: lessons from Haiti

Nick Rose, Peter Hughes, Sherese Ali & Lynne Jones

Following the 2010 Haiti earthquake, there was a need for specialist services for severely mentally ill people who were presenting to the emergency medical clinics set up for displaced people. That need was unmet. Using guidelines drawn up by the Inter-Agency Standing Committee (IASC), and piloting the Health Information System (HIS) of diagnostic categories in mental health, weekly mental health clinics were begun in eight mobile clinics. A psychiatric liaison service was also started in the main casualty hospital. Haitian general practitioners and psychosocial workers, who received on-the-job training and supervision from the authors, ran these services. This integrated mental health/primary health care model was successful in engaging severely mentally ill patients in treatment; however, the scale of the disaster meant that only a relatively small proportion of the displaced population could access help. This limitation raised a number of questions about the practicality and sustainability of the IASC model in resource poor countries, with poorly developed community services, hit by large scale emergencies, which the authors address.

Keywords: earthquake, Haiti, large scale emergencies, mental health services, resource poor countries

The Haitian Government reported that an estimated 220,000 people were killed and 1.5 million displaced in the 2010 Haitian earthquake (United Nations High Commissioner for Refugees (UNHCR), 2010), although a more recent draft report

commissioned by the United States Agency for International Development (USAID) has recently claimed that the mortality figures may have been overestimated at least threefold (BBC, 2011). Nevertheless, whatever the final estimate, the scale of the disaster was immense; occurring in a country where four out of five people already lived below the poverty line, and where the health infrastructure was weak. Haiti ranks last for health care spending in the Western Hemisphere (World Bank, 2006) with health provision unregulated and patchy. Only 30% of health facilities were public, mostly in urban areas, and 70% of rural health services were provided by nongovernmental organisations (NGOs), with 40% of the rural population having no access to primary health care (World Bank, 2006; WHO, 2010a). Mental health resources were highly centralised, and consisted of two psychiatric hospitals in Port-au-Prince, both of which were understaffed and in a poor state of repair. There were only 0.2 psychiatrists per 100,000 general population, as compared to 11 per 100,000 in the United Kingdom (WHO, 2005), most working in the capital city. Outside of Port-au-Prince, there was little access to psychosocial support or effective social services. There was, however, a widespread network of traditional religious healers. *Vodou* beliefs are common in Haiti, and these beliefs support a religious health care system that

incorporates healing practices (WHO, 2010a). *Vodou* beliefs are also reflected in the presentation and causal explanation of severe mental illness. This fragile health infrastructure was overwhelmed following the destruction of at least eight hospitals, as well as the deaths and injuries of essential personnel during the earthquake. A massive aid effort was mobilised, which included attempts to meet the needs of those with severe mental illness. This paper describes how one group of mental health professionals undertook this task.

Meeting mental health needs following large scale disasters

WHO guidelines, for providing mental health assistance after disasters, have previously suggested that there are three groups of distressed people, each requiring a different response (WHO, 2007). Those with mild psychological distress that resolves in a few days or weeks, and needs no specific intervention, estimated at 20–40% of the affected population; Those with moderate or severe psychological distress, who would benefit from basic non specialist, psychosocial interventions, such as psychological first aid and interventions that strengthen community and family, are estimated at 30–50% of the affected population. Finally, are those with a mental disorder, the incidence of which appears to temporarily double following a disaster. Within this last group, the prevalence of mild to moderate disorders, such as mild to moderate depression or anxiety, would be expected to increase from a baseline of 10% (WHO, 2004) to 20%, while the prevalence of severe disorders could rise from 2–3% to 3–4%. As a result, how to undertake psychosocial and mental health work after disasters has long been the subject of debate. For example, there has been no agreement on the public

health value of the posttraumatic stress disorder (PTSD) concept and no agreement on the appropriateness of 'vertical' trauma focused services (van Ommeren et al., 2005). The needs of people with severe mental disorders, in post disaster situations, have also been slow to get recognition. After Hurricane Katrina in 2005, it was estimated that the prevalence of severe mental disorder almost doubled from 6.1 to 11.3% of the affected population, yet psychosocial agencies tended to focus on the immediate traumatic responses (Kessler et al., 2006). This lack of consensus to the approach meant that mental health was only briefly discussed in the first edition of the Sphere guidelines on humanitarian standards, produced by a group of leading international aid organisations in 1998 (published as *The Human Charter and Minimum Standards in Disaster Response*, commonly referred to as the *Sphere Handbook*, currently in its 2011 edition). Controversy continued during the Asian Tsunami, when psychosocial agencies were widely criticised for lack of agreed standards and varying approaches. This experience led directly to the creation of the Inter-Agency Standing Committee (IASC) task force set up to agree guidelines for the practice of mental health and psychosocial work in emergency settings. Representatives from 27 international governmental and nongovernmental organisations worked over two years, in consultation with experts from more than 100 nongovernmental organisations, academic institutions, and professional organisations. The resulting *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* represent an international consensus on the type of care, and care system that is suitable for emergency situations (Inter-Agency Standing Committee, 2007; Wessells & van Ommeren, 2008).

The hierarchy of responses recommended by the IASC guidelines includes: advocacy for equitable and dignified access to basic necessities and protection for the majority; social interventions that reconnect disrupted families and communities, and help them restart their lives; more focused individual psychosocial support for those who suffer more severe non pathological reactions; and clinical interventions for the most severely affected minority. Other authors have emphasised the importance of acknowledging and building on the natural resilience of individuals and communities. Resilience is seen as a process rather than an end point, and is reinforced through strategies such as psychological first aid, and enabling displaced communities to be as self-reliant as possible (Raphael, 2008; Bonanno et al., 2010).

In relation to care for people with severe mental disorders, the IASC guidance recommends integrating mental health provision with primary care clinics (Box 1),

which is consistent with the WHO strategy for mental health provision in poor nations (WHO, 2008). This guidance also recommends giving appropriate support to local services and institutions caring for people with severe mental disorders and other mental and neurological disabilities.

Saraceno et al. (2007) have identified a number of barriers to integrating mental health services into primary care. One is the work overload suffered by most primary health care workers, which means they see themselves as having no time for mentally ill patients. The second is providing short, theoretical training courses without follow up supervision. These constraints may result in a failure to distinguish distress from disorder, and consequent overmedicalisation, and overprescribing of psychotropic drugs, for minor complaints. A third barrier can be the lack of psychotropic drugs, so that even trained workers lack the means to treat severe mental disorders.

Box 1: Minimum response actions to address needs of people with severe mental disorders in emergencies (from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*)

1. Assess situation (including surviving health capacity)
2. Ensure adequate supplies of essential psychiatric drugs
3. Enable at least one member of emergency primary health care (PHC) team to provide frontline mental health care
4. Train and supervise available PHC staff in the frontline care of severe mental disorders
5. Avoid overburdening PHC workers with multiple different training sessions
6. Establish mental health care at additional logical points of access (including emergency rooms)
7. Try to avoid creating parallel mental health services focused on specific diagnoses, or narrow groups
8. Inform population about the availability of mental health care
9. Work with local community structures to discover, visit, and assist people with severe mental disorders
10. Be involved in all inter-agency coordination on mental health

The *IASC Guidelines* address each of these barriers, recommending that theoretical training is always accompanied by supervised on-the-job training, and that primary health care (PHC) staff are assisted and trained in time management to allow dedicated time for mental health work. The guidelines also recommend training in simple psychological interventions for non pathological distress, and rational prescribing. Also important is investment in systems of care, rather than individual staff members, and ensuring that treatment conforms to international standards of care (Cohen, 2001).

The IASC recommended model of integrating mental and physical healthcare in emergency and conflict zone situations is now well established practice (van Ommeren et al., 2005; Budosan et al., 2007; Jones et al., 2009; Rose, 2011; Mueller et al., 2011). However, the scale of the disaster in Haiti and the complete absence of community based mental health care prior to the earthquake provided a challenging opportunity to test the *Guidelines* in an emergency, resource poor setting of immense proportions.

Our response to the Haiti emergency

A rapid assessment of need was done within 12 days after the earthquake. This included coordination with other local and international agencies planning to provide mental health and psychosocial care. Little information was available on Haiti's pre-existing mental health needs, therefore the assessment included visiting both of the national psychiatric hospitals in Port-au-Prince, and talking with surviving staff. Emergency clinics for displaced people, set up by a number of medical aid organisations, were also visited as was the main Emergency

Room for Port-au-Prince situated in the grounds of the partly destroyed University Hospital, l'Hopital de l'Université d'Etat d'Haiti (HUEH).

At this stage, the International Medical Corps was responsible for providing 15 community clinics, as well as Emergency Room services at HUEH. The assessment revealed that the majority of people attending the emergency services reported feeling shocked and afraid, with common complaints of palpitations and a persistent feeling that the *'ground was moving'*. People were also being seen with severe mood disorder and psychotic illness, clinical problems that the medical teams were poorly equipped to manage.

The majority of the affected population were living in overcrowded makeshift shelters and/or crowded camps for displaced people. They were frustrated and angry at the difficulties of obtaining basic necessities, and at the lack of security. Therefore, advocacy to change these conditions was a psychosocial priority from the start. Most people had suffered losses of some kind. Some individuals had been trapped under the rubble for long periods. A child patient of one of the authors had been discovered after nine days for example. Because of the rapid disposal of bodies in mass graves and the persistent problem of uncleared rubble, many had been unable to find or identify the remains of their loved ones, which made mourning difficult. Added to this, fear and stress was generated by continuing government warnings of the likelihood of new quakes. Given these conditions, the resilience of the population and the degree to which they were helping themselves was remarkable. Markets appeared in the makeshift camps in the first days after the disaster, as did small enterprises such as phone charging, hair dressing and the

sale of prostheses, crutches and wheel chairs.

Assessment of the two psychiatric institutions revealed a particularly disturbing situation. In the acute psychiatric hospital near the city centre, 11 of the original 100 inpatients lived in degraded and insanitary conditions with no running water, no power, filthy accommodation, no bedding, and no clothes.

Many of the staff were understandably preoccupied with their own affairs, because they were bereaved, or their homes were destroyed, and did not return to work for weeks. Those who did come to work had to care for at least 150 outpatients a day in a tent surrounded by an encampment of 120 displaced families that had taken refuge in the hospital yard.

In the long stay hospital on the outskirts of Port-au-Prince, many patients had run away when the wall collapsed and the remainder slept in the open-air as the rooms were considered unsafe.

At least 90 international and local agencies were offering psychosocial support after the earthquake. Coordination took place through the UN led mental health and psychosocial support sub-cluster, which met twice a week. A representative from the Haitian Ministry of Health was joint chair of this meeting. Mapping of agency activities made it clear that very few of them were providing psychiatric services for the more severely affected section of the population, either in the community or in existing psychiatric institutions. Only two agencies, apart from our own, were providing psychiatric care through clinics in Port-au-Prince. In the earthquake affected areas outside the city, there were no psychiatric services available. The International Medical Corps then made the development of accessible psychiatric

support and services for this group a priority.

Interventions to support the acute psychiatric hospital included: the provision of a staff transport vehicle, a generator, bedding, patient clothes, hygiene kits, cleaning materials and essential medication. At the request of staff, a series of twice weekly training seminars was organised for three months. Also at their request, these seminars were then extended for eight weeks. These aimed to support staff in evaluating and developing their care and treatment practices. A generator was also provided for the second hospital, which cared for longer stay patients. Other organisations provided food and tents. However, in light of the continued functioning of both hospitals, albeit at a reduced level, we decided that further support of the two institutions required resources beyond the capacity of an emergency health agency. In line with the *IASC Guidelines*, we therefore prioritised the rapid development of community based mental health services that would both serve emergency needs and decrease the demand for institutional care. Since a large number of people with mental health problems were being seen in the Emergency Room following the earthquake, it was also decided to provide a temporary psychiatric liaison service for the University Hospital, HUEH. A psychiatric liaison service at the University Hospital started two weeks after the earthquake. In consultation with the hospital's Haitian medical director and the Government's Department of Health, it was agreed that a Haitian psychosocial worker would be employed to triage referrals, supervised by an international or Haitian psychiatrist. The psychologist provided both group and individual therapy, and a psychiatrist was available daily to see complex cases, as well as patients who might

need psychotropic medication. After six months, as earthquake related problems diminished, the medical and psychiatric liaison services were gradually withdrawn. Community based mental health services began within a month of the earthquake in locations with the greatest concentration of displaced people. The model used followed *IASC Guidelines* and was supported by Ministry of Health officials. Mental health clinics were integrated into eight busy primary healthcare centres, each serving a displaced population of between 10 and 15,000. Most took place under canvass since many surviving buildings remained unsafe, and staff and patients understandably felt safer in the open. The clinics were located in the western suburbs of Port-au-Prince, and in the earthquake damaged South West and Southern provinces.

To address the time management problem, we suggested that mental health care be organised in a manner similar to antenatal care, by providing a 'mental health' clinic once a week. At each primary health care clinic, a Haitian general practitioner was therefore released from general duties for half a day a week to run this service. Thus, rather than seeing such cases as a time consuming interruption, the practitioner could give them additional time, and more dedicated attention. It also allowed for concentrated periods of on-the-job supervision by an international psychiatrist (one of the authors), or a Haitian psychiatrist learning to become a workplace trainer. Each mental health clinic, including the one attached to the emergency room, was co-ordinated by a community psychosocial worker, usually a previously unemployed Haitian psychologist or nurse. These were recruited as full time mental health staff working with patients on a daily basis. As well as their service coordination role therefore, they were able to undertake

preliminary assessments, provide individual and group therapeutic activities, liaise with other community resources such as local leaders, aid organisations, and traditional healers, and act as the point of referral for victims of sexual and gender based violence. Each psychosocial worker also had the task of recruiting and supervising a dozen local community volunteers who could promote good mental health, support appropriate mourning processes, identify people suffering from severe mental illness in their neighbourhood, engage them in treatment, and help them access local resources. Psychosocial workers liaised closely with the general practitioner in charge of their weekly mental health clinic, and were clinically supervised by the visiting international or local psychiatrist. In addition, a senior psychosocial worker, who organised a separate training programme to support and develop the activities and skills of the psychosocial workers, managed them.

A patient file system was established to record demographic, clinical and trauma related information. In addition, team members were taught to use the mental health categories and case definitions newly developed in the Health Information System (HIS) of the UNHCR, for use by primary care staff working in refugee camps (UNHCR, 2010). We used a pilot version, which included case definitions, loaned to us by UNHCR, as yet unpublished. The categories are based on a recommendation in *IASC Guidelines* (2007), and are designed to simplify the diagnosis of mental distress and disorders by primary health care workers, so that they can identify probable psychiatric cases. The prior failure to include anything but the most gross mental health diagnostic categories in HIS systems, in many low and middle income countries,

has added to the difficulties of primary health care workers giving these patients attention and care. The categories used (Table 1) are straightforward, and easily recognised by health workers. They also, to a large degree, match the newly created mental health Gap Action programme (mhGAP) priority conditions (WHO, 2010b). Establishing the community service in Haiti provided an opportunity to informally field test these definitions. Essential psychotropic medication, included in the WHO essential medicine list, The Inter-Agency Health Kit (WHO, 2006) was made available in all clinics.

Training played a central role in clinic activities. For the general practitioners, the aim was for them to be able to clinically manage most people presenting with severe mental illness within three months. This was done through workplace training and attending a weekly half day teaching programme. Assessment involved a combination of workplace Assessed Clinical Encounters, Case Based Discussions, and an end-of-training examination consisting of Objective Structured Clinical Examinations (OSCEs) and an oral exam.

The curriculum of the teaching programme was based on the textbook *Where There Is No Psychiatrist* (Patel, 2003), *IASC Guidelines*, and a draft of the *mhGAP Intervention Guide* (WHO, 2010b). Psychosocial workers also attended the half-day teaching programme, and were supervised in providing basic, individual and group interventions focused mainly on anxiety management and problem solving. Two part time Haitian psychiatrists were recruited to train as workplace supervisors and assessors of the general practitioners, so that the programme could become independent of international staff, and therefore more sustainable.

Patients seen

During the first five months of the community clinics, a total of 431 patients were assessed on eight sites. Assessments included a supervising psychiatrist in 65% of cases. Of the patients seen, 22% had experienced the loss of a first-degree relative in the earthquake, and 74% had suffered serious damage or collapse of their dwelling (Table 2). About half of those assessed had seen a traditional healer for their complaint, often at great expense. By far the most

Table 1. Health Information System (UNHCR, 2010)

Health Information System (HIS) for use in humanitarian settings: Mental Health Categories	
HIS 1	Epilepsy/seizures
HIS 2	Alcohol or other substance use disorder
HIS 3	Mental retardation/ intellectual disability
HIS 4	Psychotic disorder
HIS 5	Severe emotional disorder
HIS 6	Other psychological complaints (including anxiety) not resulting in major day-to-day dysfunction
HIS 7	Medically unexplained somatic complaint
No HIS category for:	Dementia
	Other, for psychiatric disorders not covered in the seven categories
	No psychiatric disorder present

Table 2 Clinic activity (data February–June 2010)

	General hospital	Primary care clinics (8 sites)
Number of new patients seen	201	431
Total clinical consultations	356	722
Mean age	30 (range 3–75)	32 (range 0.5–88)
Number of females seen	59%	64%
Children seen (under 16)	13%	13%
Loss of 1 st degree relative	29%	22%
Loss of non 1 st degree relative	12%	13%
Housing destroyed by earthquake	27%	58%
Housing damaged, but habitable	15%	16%
Seen by traditional healer	15%	47%
Assessment by GP or psychosocial worker supervised by a psychiatrist	55%	65%
Assessment only	5%	1%
Main intervention:		
Medication	20%	20%
Psycho education	11%	40%
Counselling	6%	5%
Psychosocial support	57%	34%

common mental health category was 'other psychological complaints' (HIS 6) which accounted for 55% of all patients seen (Table 3). These complaints were overwhelmingly of anxiety, usually focused on a fear of buildings falling, or of losing people close to them. Psychosis (HIS 4) accounted for 13% of patients seen and epilepsy (HIS 1) for 11%. Surprisingly only 3% of patients had severe emotional disorder (bipolar or severe depression) and only five cases of alcohol or other substance use disorder were diagnosed. Symptoms of grief were common, and it was often hard to disentangle what was culturally normal, from what was morbid. Concerning treatment, 40% received psycho education, which included anxiety management; 34% psychosocial support, usually in the form of help in solving basic needs related problems;

and 5% focused counselling. Only 20% were prescribed medication.

Comparing diagnoses made in community clinics during the first five months after the earthquake (February–June), with the next five months (July–November), there was a 10-fold reduction of patients presenting with minor disorders as recorded under the HIS category 6 of 'other psychological complaints' (Table 3). By contrast, severe emotional disorders increased from 3% to 21%, and medically unexplained complaints increased from 1% to 15%. Dementia also presented more frequently during this later period, although there was little change in the referral pattern of other severe and chronic disorders, such as people with psychosis, learning difficulties or epilepsy.

The general hospital clinic appeared to pick up a similar range of clinical problems as

Table 3 *Diagnosis of newly assessed patients (data February–November 2010)*

Health Information System (HIS) diagnosis for use in humanitarian settings: Mental health categories (probable cases)	General hospital Feb–June	Primary care clinics Feb–June	Primary care clinics July–Nov	Total
No psychiatric diagnosis	0	27 (6%)	5 (1%)	27 (3%)
HIS 1 Epilepsy	5 (3%)	47 (11%)	78 (16%)	130 (12%)
HIS 2 Alcohol/substance misuse	0	5 (1%)	11 (2%)	16 (1%)
HIS 3 Learning disability	0	21 (5%)	27 (6%)	48 (4%)
HIS 4 Psychotic disorder	29 (17%)	58 (13%)	92 (19%)	179 (17%)
HIS 5 Severe emotional disorder	30 (18%)	15 (3%)	98 (21%)	143 (13%)
HIS 6 Other psychological complaint	80 (47%)	239 (55%)	23 (5%)	342 (32%)
HIS 7 Medically unexplained somatic complaint	5 (3%)	4 (1%)	72 (15%)	81 (8%)
Dementia	1 (1%)	5 (1%)	29 (6%)	35 (3%)
Other	21 (12%)	10 (2%)	44 (9%)	75 (7%)
Total number of assessments	171	431	474	1076

the community clinics. This probably reflected the fact that large numbers of displaced people in nearby city centre camps used the hospital for primary care. However, there was a six-fold increase in the number of patients seen with severe emotional disorders at the hospital, as compared to primary care, during the same period after the earthquake. Many of these patients had life threatening depressive disorders, and were often in a state of extreme physical neglect requiring medical intervention. The general hospital emergency room received many cases of severe gender based violence, sometimes with children as the victims. Poor security and lighting in many of the camps, as well as disrupted community links, may have aggravated this problem. Four particularly severely affected victims of sexual abuse

were assessed and followed up by the hospital psychosocial worker.

Concerning staff training, over the five-month period starting from February 2010, 140 health workers attended one of six programmes of mental health seminars, each held on a different site. Of these, 73 were nurses and 31 medical practitioners. The rest included psychologists, health assistants and a small number of translators. Twelve medical practitioners completed the combined seminar and work place training programme, and successfully passed the assessment programme.

Discussion

The patient information, recorded in Tables 2 and 3, represent an audit of who presented at the mental health clinics, but cannot give an accurate picture of needs

within the community. The data does, however, give a snapshot of what people will bring to primary health care clinics in an emergency situation, and how that picture changes over time. The significant presence of epilepsy and psychosis justified the attention given by the programme in providing services for those with severe mental disorders, and is consistent with experiences in other emergencies (Jones et al., 2009). The 10-fold drop in incidence of HIS category 6, from 55% during the first five months after the earthquake to 5% in the subsequent five-month period, almost certainly reflects the temporary nature of the surge of anxiety following the disaster. These cases appear to have been partly replaced by cases of severe emotional disorders, for the most part depression, enduring grief reactions, and somatic complaints. This may reflect the enduring problems of loss, and the stress of daily life in temporary and inadequate shelters.

In terms of setting up the mental health clinical and training programme, the IASC model proved to be a useful operational framework. In fluid and insecure circumstances, with enormous logistical challenges, it was possible to integrate a mental health service into at least half of the emergency mobile primary care clinics set up by the International Medical Corps within the disaster hit areas. The UNHCR HIS system also proved to be a useful tool for training staff, and related neatly to the mhGAP curriculum. However we had to add three new HIS categories: no psychiatric disorder, dementia, and 'other' for psychiatric conditions not covered under the seven headings.

Dilemmas encountered

Of the many dilemmas faced in developing and running the programme, three related

dilemmas stood out: the sustainability of the integrated mental health/primary care model, post emergency in a country with poorly developed primary health infrastructure, and no history of community psychiatry; the possibility of unintended bad consequences; and whether it was wise to invest in community mental health services, rather than reinforcing already established central ones.

The moral case for providing local emergency clinics after the earthquake is clear, but should a mass disaster be used as an opportunity for Western agencies to promote community mental health services, particularly when central services are so under-developed? Additionally, is it reasonable to set up a model that may prove unsustainable, since it is so dependent on the continuing flow of foreign aid, and the future preparedness and capacity of the Haitian government to take over responsibility? As far the model of care was concerned, we felt that this was something on which there was an international consensus, rather than being western imposed clinical practice (WHO, 2009). Also, the patchily provided medical system in Haiti, with its heavy dependence on private, urban based services did not provide an ideal structure in which to integrate community based mental health care. As far as donor commitment goes, although this has been maintained to date, it remains something to be advocated for in these uncertain economic times. It will need expensive long term institution building if the model is to be rolled out nationally. At the very least, we hoped to demonstrate to the Haitian government the benefit of free services provided through the innumerable mobile clinics that were running during the emergency, and to model how mental health care could be integrated into primary care. We were involved in discussions about

the possibility of setting up publically funded primary health care, but there was no guarantee that this would happen. So the question arises as to the value of training primary healthcare workers for a service that may not be sustained, and the ethics of providing care free of charge when that too may not last. Recognising that we could not predict the long term direction of planning with elections about to happen, we reasoned that it was worth training a cadre of primary care staff and psychosocial workers who could be a resource for the country in the longer term.

All humanitarian interventions risk unintended bad consequences. For example, providing services to hundreds of tented camps inevitably creates dependency, although the continuing failure to clear rubble and build effective new homes has meant such services have remained essential. Another important consequence is that the presence of a competent outside agency providing free medical services may undermine local incentives to manage problems with local resources. There was certainly no shortage of Haitian doctors in the country, many having run small private practices before the earthquake. Indeed, the mobile emergency clinics set up by the International Medical Corps were staffed by doctors easily recruited from the private sector whose own clinics were out of action, as well as a small number of ministry of health (MOH) staff out of work because their clinics had been destroyed. So, although we avoided recruiting from functioning MOH services to prevent undermining public services, we may have inadvertently undermined the private sector. Another consequence of providing free services, which included free medication, was that drugs donated to Haiti found their way onto the market place. We had

direct evidence, for example, of donated psychotropic drugs being sold to patients. All of these unintended consequences of intervention need further evaluation to inform future practice.

The final dilemma arose from the decision to focus mainly on creating new community services, rather developing the two existing psychiatric institutions. This decision was made partly in line with the principles incorporated in the IASC guidance, and partly on pragmatic grounds. We had limited resources, and were unable to provide a service to both displaced people, and large psychiatric institutions. We also calculated that since the institutions were providing at least some level of service, our priority should be to reach displaced people with severe mental health problems who would otherwise have no access to treatment. Our concern, in retrospect, was whether we could have detected a larger number of severely ill new patients by using our resources to improve access to the two established psychiatric hospitals. Certainly, community services are good at engaging people in treatment because of better accessibility, but there were insufficient resources to scale them up across a metropolitan population of 3.5 million people, let alone a country the size of Wales. Additionally, there are economies of scale in centralising, even if some will not access the treatment. So the dilemma was, with scarce resources, could we have done more for the severely mentally ill population as a whole by reinforcing the capacity of a centralist approach, rather than setting up a newly created integration of specialist mental health and primary care as recommended by the IASC? Lacking hard evidence, our impression was that few of the patients seen in the community clinics would have attended hospital, particularly in the more distant clinics, where we saw

patients who had not been able to access care before. A hospital centred approach may have helped to improve both psychiatric out patient and inpatient care quality, but may not have attracted many extra new patients.

What lessons were learnt from our intervention?

Some things went well, and we would repeat them in similar circumstances. Others went less well, and pose real questions for future interventions.

What worked well was the ability of the clinics to rapidly identify and treat severely ill people in the camps, providing a service that complemented the psychosocial activities provided by other less specialist organisations. Integrating a specialist service with the emergency mobile clinics undoubtedly helped with this. The supervised Haitian general practitioners were often already aware of untreated psychiatric cases on their patch, and with the help of the psychosocial worker, were able to get them to attend the specialist clinic. In addition, partly because the clinics were so accessible (moving within the city was extremely difficult and time consuming), patients almost always came with family or concerned neighbours. So even quite disturbed patients could be managed with this community support. Of course, given the level of social disruption caused by the disaster, some patients had no support and did not seek help. However, in time, the psychosocial worker's ability to network within the camps led to many of these more isolated individuals being engaged in treatment.

The second thing that seemed to work really well was on-the-job training. Although this was often difficult logistically, because of security or transport problems, it did mean that supervisors had regular first hand

experience of a wide range of clinics and were able to become more attuned to the cultural and contextual differences inherent in their work, something particularly important for the international supervisors. Trainees also valued the immediacy and personal relevance of feedback, and felt more confident to manage complex cases. Significantly, this training model proved resilient enough to cope with busy and often chaotic emergency clinics.

We did, however, have reservations about one key aspect of the *IASC Guidelines*. Given the scale of the disaster, it proved unrealistic to provide mental health care in every emergency primary health care location, as recommended in the guidelines. Even if the on-the-job training component had been diluted, the specialist resources needed to scale up the integrated mental health/primary care model for all the emergency clinics serving a displaced population of well over a million people would have been considerable, and beyond the capacity of all existing medical aid organisations put together. We were also opposed to weakening the amount of on-the-job supervision provided, viewing this as an essential part of the training. Recognising this, we tried wherever possible to place mental health clinics in central locations. Two were in tents within the grounds of district hospitals providing primary and secondary general medical care, while others were in locations convenient enough to allow referrals from a number of nearby primary care clinics. This still left the vast majority of displaced people with limited, or no, access to mental health care. In future disasters, we should pay greater attention to the setting up of carefully situated integrated clinics operating as referral hubs, serving clusters of emergency primary care clinics. We would also employ psychosocial workers to develop

and support this more, dispersed way of working.

Building an effective health service for the long term remains an enormous challenge for Haiti, not least because of the extent of institution building required to increase the capacity of the Department of Health, and to train an appropriate national workforce. At present there are few resources to train community mental health nurses, or to create a new cadre of community mental health worker. There is some cause for optimism though. Following negotiations with the Haitian Department of Health by the International Medical Corps, together with Partners in Health, *Médecins Sans Frontières* and *Médecins du Monde*, community mental health was included in the draft Haitian National Health Strategy (2010). However even if long term resources were available to the government, mental health services may not be prioritised in a country with a long history of undeveloped basic public services, which is going to be pre-occupied for years to come with the political, economic and social repercussions of the earthquake.

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Strategy for providing integrated mental health/psychosocial support in post earthquake Haiti

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The recent earthquake in Haiti exposed all the weaknesses in the mental health care system existing prior to the earthquake. This paper describes the strategy developed by the Dutch nongovernmental organisation Cordaid for providing integrated mental health and psychosocial support in Haiti after the earthquake. The strategy aimed to address mental health and psychosocial needs in the early recovery and reconsolidation phases, and to build mental health capacity of community level and primary health care providers. This would result in the establishment of a referral system between the community and health care sectors. The results of the implementation showed that mental health trainings were a feasible intervention for Haiti, but so far they have not yet resulted in change of practice of primary health care workers, and the goal of a referral system is still in an embryonic phase.

Keywords: community level workers, earthquake, Haiti, mental health, primary healthcare, psychosocial support, training

Introduction

On 12 January 2010 Haiti was struck by a catastrophic earthquake. Its epicentre was near the town of Léogâne, approximately 25 km (16 miles) west of Port-au-Prince, Haiti's capital. An estimated three million people were affected by the quake. According to the information from the Interior Ministry of Haiti, as of 10 March 2010, 222,653 people were registered as dead, and 310,928 were wounded. More than 1.5

million were in need of basic assistance, and 660,000 people were displaced. An estimated 250,000 residences and 30,000 commercial buildings had collapsed, or were severely damaged.

Background: mental health needs in Haiti

The capacity of the mental health system prior to the earthquake in Haiti was weak, but the available data on the number of mental health professionals differ depending on the source. In the Mental Health Atlas (World Health Organization, 2005), no data were available. A 2003 PAHO/WHO report counted 10 psychiatrists and nine psychiatric nurses working in the public sector, and two government psychiatric hospitals in Port-au-Prince (World Health Organisation, 2010a). These figures are contested (Lecomte and Raphael, 2010). According to Clouin (2009), before the earthquake there were 23 psychiatrists, 10 psychiatric nurses in public sector, approximately 50 psychologists (at Master's level) and an undetermined number of social workers in 2008. According to the World Health Organization (2010), most of the services provided by mental health professionals were in the private sector, and based primarily in Port-au-Prince. Mental health services outside of Port-au-Prince were practically non-existent. At the country's second largest hospital, l'Hôpital

Universitaire Justinien, in the city of Cap-Haïtien in the north, psychiatric services were limited to monthly visits by a psychiatrist from Port-au Prince (World Health Organization, 2010a). Before the earthquake, there was only one psychiatrist providing services in the south of the country, in the town of Les Cayes (personal communication Dr Caroline Coicou, 22 April 2010).

The availability of follow-up community mental health treatment was also very limited, and regardless of the type of illness, family members were usually the first to be consulted regarding treatment and advice. According to the World Health Organization (2010), traditional psychiatric drugs were generally available on the market before the earthquake. Only a small number of people with private health insurance were eligible to receive a reimbursement for the purchase of medication.

There is no epidemiological study on the prevalence of mental health problems in Haiti (Caron, 2010). The World Health Organization (2010a) estimated the distribution of diagnoses seen at a psychiatric hospital in Haiti (prior to the earthquake), as follows: schizophrenia (50%), bipolar disorder with mania (30%), other psychoses (15%) and epilepsy (5%). This breakdown is not dissimilar to in-patient populations in other countries, but does not show the actual prevalence of mental disorders within the community. Pre-earthquake studies found high levels of symptoms of posttraumatic stress disorder (PTSD), depression, anxiety and somatic problems in victims of conjugal violence (Benjamin, 2008). Clouin (2009) reported that the majority of beneficiaries of a nutritional programme suffered from depression after the 2008 hurricane in Gonaïve. Caron (2010) uses a conservative estimate of 190,000 people (5% of 3.8 million inhabitants of Port-au-

Prince) suffering from symptoms of posttraumatic stress after the 2010 earthquake.

Traditional mental health services

A very large number of Haitians, especially those of lower education and economic status, made use of traditional practitioners, i.e. herbalists (*dokte fey*) or religious healers, i.e. *houngan* and *mambo* (male and female voodoo priests) when faced with mental problems. Also, Christian churches in Haiti help people cope with mental and emotional problems (Bijoux, 2010). Dispensaries, religious health facilities and herbalists were by far the most common choice for treatment (80% of all consultations before the earthquake), since they were less expensive and more easily available. Hospital clinics and other types of healers were physically less accessible and their treatments more expensive. Patients therefore referred to them less frequently (only 6% and 5% of consultations, respectively) to treat more uncommon and severe mental problems (World Health Organization, 2010a).

In recent years, Haitians have mobilised a network of community resources to sensitise the population to social and health issues related to various problems, such as violence against women, HIV/AIDS and children's rights. These grassroots organisations have also served as self-help and support groups for people facing severe life events and ongoing stress (World Health Organization, 2010). Many of these organisations were affected by the recent earthquake in terms of destruction of their infrastructure and loss of lives of their staff, but most of them, with the help of international community, resumed their activities to some extent very soon after the disaster. Also, Christian churches in Haiti helped people cope with mental and emotional problems (Bijoux, 2010).

Mental health & psychosocial support (MHPSS) after the earthquake

A Mental Health & Psychosocial Support (MHPSS) Working Group was established within the cluster system in Haiti in the aftermath of the 2010 earthquake (Schininá et al., 2010) which issued a Guidance Note for MHPSS based on the *IASC Mental Health and Psychosocial Support Guidelines in Emergency Settings* (Inter-Agency Standing Committee, 2007). According to Lecomte (2010a), there were about 100 nongovernmental organisations (NGOs) active in mental health in Haiti after the earthquake, offering 17 different modalities of MHPS intervention. Various models of providing MHPSS were applied including: a) local and foreign mental health professionals providing short-term direct clinical care for mental health problems, including psychiatric disorders, and training lay volunteers, local psychologists and primary health care (PHC) physicians on MHPS issues; b) organisation of child friendly spaces; c) individual and group psychological support; d) recreational activities for beneficiaries; and e) advocating for mental health issues (Mental Health and Psychosocial Support Network, 2010). Based on the review of relevant literature (both international and local), extensive field based assessments (described below), and the donor's requirements, Dutch international NGO (INGO) Cordaid (Caritas/Cordaid) decided to provide an integrated model of MHPSS in five administrative departments of Haiti; Department West (Delmas area of Port-au-Prince, Carrefour, Leogane, Petit Goave), Department Artibonite (Gonaives), Department North (Cap-Haitien), Department North-East (Fort Liberté) and Department South-East (Jacmel, Cayes Jacmel).

Strategy for providing integrated mental health/psychosocial support

Cordaid started providing MHPS support in Department West, one of the hardest hit by the earthquake, and with the aim of replicating the model to expand activities to other targeted departments with a high number of displaced earthquake affected population (One Response, 2010). The integrated MHPS support was provided in cooperation with local NGO partners, the Ministry of Public Health and Population (MPHP) and local health departments. Community level workers from local NGO¹ partners delivered community based MHPS interventions in the targeted areas, and identified cases for referral to PHC workers. Identification, recruitment and a series of short (three to five day) mental health trainings for community level workers were supplied by the Cordaid's mental health team, comprising general practitioners, psychologists and social workers, additionally supported by general practitioners and international and local psychiatrists as external consultants. At the same time, the programme aimed to initiate a process of integration of mental health into primary health care (PHC) by training PHC workers of local NGO partners and the establishment of a referral system between targeted communities and NGO and government health systems.

Methods

Methods of assessment of MHPS needs/services

A field based assessment in Department West was done in March and April 2010. Additional assessments were done from October to January 2011 in all other departments, before the start of implementation in these areas.

In all assessments, data collection methods included semi-structured interviews with key informants, focus group discussions with

beneficiaries and unstructured observation of patient encounters in primary health care. Quantitative data collection methods included a community survey and, in Department West only, a multiple choice mental health knowledge test. Sources of information included: representatives of local partner NGOs, representatives of INGOs involved in MHPSS in Haiti, MPHP, the Humanitarian Aid Department of the European Commission formerly known as the European Community Humanitarian Aid Office (ECHO), institutions teaching social work and psychology, local mental health professionals, general health professionals, representatives of communities and direct beneficiaries. The interviews began with the exploration of mental health needs and services, and continued with the focus on organisation in MHPS support and ideas on how to best deliver it. Information from beneficiaries, i.e. the earthquake-affected population, was collected during focus group discussions. In most of the cases, focus groups were held with members of one extended family. The topic guide for discussions included: questions related to different aspects of wellbeing of beneficiaries (emotional, economic, social, family, religious and cognitive); their need for MHPS support; and ideas on how to best deliver it. Interviews and discussions were stopped when no new information or themes emerged. Unstructured observation of patient encounters was held in primary health care and mobile clinics with the expatriate mental health advisor as an observer. The community survey was done during a half-a-day participatory workshop in the Delmas area, with a questionnaire on emotional, economic, social, family, religious and cognitive aspects of wellbeing. The mental health knowledge tests in Creole and French were given to five community level

and five PHC workers, respectively, at the same workshop. Both tests were abbreviated versions of the tests previously used in the post tsunami mental health project in Sri Lanka (Budosan and Jones, 2009). The test for community level workers contained 10, and the test for PHC workers 12, questions on identification and treatment of stress, and common and severe mental disorders.

Methods of implementation

The role of community and PHC workers within the targeted Haitian communities and existing PHC system, respectively, and their expressed interest on implementing newly acquired mental health knowledge/skills in their everyday practices, were the two most important conditions for the selection of training participants. Presentations for trainings of community level and PHC workers were developed by the expatriate Mental Health Advisor in English, and then translated into Creole and French by Cordaid's mental health team, respectively (Table 1). Presentations for PHC workers were developed according to the *Mental Health Gap Action Programme Intervention Guide (mhGAP IG)* from the WHO (World Health Organization, 2010b).

Cordaid's Mental Health Advisor developed a manual for community level workers and one for PHC workers, translated into Creole and French, respectively. Training staff resources included one international and three local psychiatrists, three local general practitioners, four local psychologists and four local social workers. The theoretical mental health knowledge was measured with 20 item multiple-choice tests, before and after, the training intervention in both groups of trainees. Both tests were abbreviated versions of tests previously used in mental health projects in Sri Lanka, post tsunami (Budosan & Jones, 2009). However,

Table 1. Topics for training community level and primary health care workers

Topics for community level workers	Topics for PHC workers
Presentation of Cordaid's MHPS programme in Haiti	Presentation of Cordaid's MHPS programme in Haiti
Mental health/psychosocial support in disaster settings	General principles of care
Definition of mental health/psychosocial	Priority mental, neurological and substance abuse conditions
Stress/distress	Depression
Loss and grief	Self-harm
Coping/resilience	Psychosis
Communication skills	Stress/distress
Psychological first aid	Other significant emotional or medically unexplained complaints
Problem solving skills, anxiety management, Anger management	Alcohol use and alcohol use disorders
Family and peer support	Drug use and drug use disorders
Groups with special needs	Essential medicines for mental disorders
Psychological support	Family and peer support
Basic stress management	Effects of extreme stressors on children and adolescents
Basics of depressive and anxiety disorders	Developmental disorders
MHPS support within traditional healing and primary health care system	Behavioural disorders
Posttraumatic stress disorder	Psychosocial interventions
Basics of psychosis	Posttraumatic stress disorder
Helping the helper	Dementia
	Epilepsy
	Mental health/psychosocial support within traditional healing and primary health care system

these contained more questions on identification and treatment of stress, and common and severe mental disorders, than those used during the assessment stage. The satisfaction of participants with various aspects of training was measured on a 4-point Likert scale: 1) very much; 2) much; 3) very little; and 4) not at all. This scale was previously used in the mental health programme in Sri Lanka, post tsunami

(Budosan et al., 2007). The aspects of the training that were evaluated were: 1) usefulness of training; 2) clarity of presentations; 3) interest of participants for the training; 4) capacity of training to empower participants to transfer received knowledge; 5) time allocated for questions; 6) treatment of participants during the training; and 7) appropriateness of training materials to the specific Haitian context.

Results

Results of the field-based assessment

In all the interviews, health professionals (PHC doctors and psychiatrists) and representatives of different organisations and communities mentioned the gap between mental health needs and the existing services in Haiti, especially after the earthquake. A majority of PHC doctors, and all psychiatrists, stated that there was an increase in mental health problems in their practices after the earthquake. In discussions, most of the beneficiaries mentioned they were suffering from a variety of mental health problems, such as loss of sleep, fear of another earthquake, lack of concentration, flashbacks, memories of the recent earthquake, and sadness expressed in terms of headache, non-specific body pain, feeling empty and/or heavy-headed. Most beneficiaries were the least satisfied with the economic and emotional aspects of their wellbeing. This result was in tune with the results from the community workshop in Delmas. In discussions, both mental health and psychosocial interventions were considered priorities by many beneficiaries. A majority of the beneficiaries mentioned lack of MHPS support in their local communities, and especially in the internally displaced persons camps. Most of PHC doctors expressed their interest in mental health training, and the process of integrating mental health care into primary health care. They mentioned that 20–30% of their patients had some mental health problems, but they lacked the knowledge/skills of how to assist them. The need for mental health training of PHC doctors was corroborated by observations of their practices, which showed that in majority of patient encounters they prescribed exclusively diazepam for all kinds of mental health problems (sleep problems, depression, anxiety, psychosomatic problems). The use

of other psychiatric medications, and any psychotherapeutic techniques in primary health care, was practically nonexistent. Mid level PHC workers were generally not involved in providing mental health assistance, mostly because PHC doctors did not see any role for them in helping people with mental problems at the primary health care level. Most PHC doctors agreed that a workshop model was the best model to deliver mental health care training in Haiti. Finally, the results of the mental health knowledge tests confirmed a need for mental health care training, of both community level and PHC workers, as a necessary prerequisite to deliver good quality MHPS interventions. Mean total percentage of correct answers on the knowledge test for community level workers was 43%, and 22% for PHC workers. Most of the interviewed representatives, PHC doctors and psychiatrists, agreed that MHPS intervention should be delivered, both in the communities and within the existing health system. Furthermore, that mental health and psychosocial interventions should complement each other. Beneficiaries expressed their wish to have MHPS assistance in their communities, including internally displaced persons camps, but also to have better access to mental health care within the existing health system, if and when needed.

Results of the implementation (first seven months of the project)

After the series of basic mental health trainings, the knowledge of community level workers improved on average by 33.8% compared to the baseline figures (Table 2), and mental health knowledge of PHC workers by 29.7% compared to the baseline figures (Table 3).

On average, 100% of community level workers and 92% of primary health care

Table 2. Results of basic MHPS trainings for community level workers in all targeted departments in Haiti

Training location	Training dates	Pre test (percentage of correct answers)	Post test (percentage of correct answers)	Improvement (in percentage compared to baseline)
Martissant	11 – 14 January 2011	45	59	31
Petit Goave	25 – 28 January 2011	40	50	25
Gonaives	8 – 11 February 2011	39	56	43.6
Jacmel	22 – 25 February 2011	57.6	58.8	2.1
Cap Haïtien	28 February – 4 March 2011	40.2	60.8	51.2
Forte Liberte	28 February – 4 March 2011	42.4	63.5	49.8

Table 3. Results of basic MHPS trainings for primary healthcare workers in all targeted Departments in Haiti

Training location	Training dates	Pre test (percentage of correct answers)	Post test (percentage of correct answers)	Improvement (in percentage compared to baseline)
Martissant	1 – 4 February 2011	29	48	65.5
Gonaives	28 March – 1 April 2011	37	49	32.4
Jacmel	28 March – 1 April 2011	44.4	54.8	23.4
Cap Haïtien	28 March – 1 April 2011	45	53	17.8
Petit Goave	4 – 8 April 2011	40	43.8	9.5

workers, who participated in the trainings, considered them to be very useful.

Discussion

In the first seven months of its implementation, Cordaid's MHPS trainings achieved satisfactory results in regard to the improvement of MHPS knowledge of both community level and PHC workers. The average improvement in knowledge of community level workers was better than, for example, occurred in a similar mental health training in Sri Lanka, post tsunami (Budosan & Jones, 2009), but lower than in the training of PHC workers in Grenada (Kutcher, Chehil, & Roberts, 2005). Lecomte (2010b) stated that community level workers, if provided with adequate training, could assist with many MHPS problems in Haiti (for example: anxiety, depression, distress, violence, problems with alcohol and drugs). Lecomte and Raphael (2010) emphasised a need for training of different providers of MHPS care in Haiti, and Raphael (2010) supported the integration of mental health into PHC as a way to reconstruct Haitian mental health care services. According to the World Health Organization (2008), primary health care for mental disorders is affordable, cost effective and generates good outcomes. In their articles on mental health in Haiti, local health and mental health professionals advocate for a strategy to provide integrated MHPS support, through integration of informal community level and formal health level sector (Caron, 2010a; Caron, 2010b; Lecomte and Raphael, 2010; Lecomte, 2010b). According to the *Guidance Note for Mental Health & Psychosocial Support in Haiti post earthquake*, well integrated mental health and psychosocial support that builds on existing capacities and cultural norms reaches more people, and is more likely to

be sustained once humanitarian aid engagement ceases. Psychological and social interventions after a disaster should be combined with the development of mental health services within PHC (van Ommeren, Saxena & Saraceno, 2005).

Main constraints and limitations

The described programme has not been able to significantly change the actual clinical practices of PHC workers. This also negatively affected the planned development of a referral system in targeted departments. Although community level workers were able to identify some cases of more severe mental health problems in need of referral, it seems that PHC workers were not motivated enough, either professionally or financially, to offer them assistance. According to the World Health Organization (2008), sustainable changes in mental health practices of PHC workers can be achieved only as a result of a several efforts combined, which include: mental health training, political will of the government, formulation of mental health policy promoting the integration of mental health into PHC, PHC workers and mental health care professionals motivated to develop community mental health services, and supervision of non-specialised health staff by mental health professionals (World Health Organization, 2008). The World Health Organization in Haiti is currently working with key local and international mental health players in Haiti to develop a mental health policy for the country. Their mental health strategy is to appoint multi-disciplinary teams of mental health professionals to supervise implementation of mental health policy in all Haitian departments. Still, according to Cordaid's experience so far, it might be a difficult task to motivate Haitian PHC workers to integrate mental health care into their practices.

A second problem the programme faced was a limited level of active cooperation from formal governmental health authorities. In spite of numerous efforts to raise the interest of government representatives for its MHPS program, Cordaid did not receive adequate responses, either from the representatives of MPHP, nor from the representatives of local health departments. This makes it very difficult to institutionalise its strategy within the government sector, and coordinate efforts with the government. Many Haitian health and mental health professionals see the limited capacity of the Haitian government as one of the major obstacles for development of a mental health strategy in Haiti (Caron, 2010b; Raphael, 2010; Henrys, 2010; Lecomte, 2010b). Mental health has been recognised by the World Health Organization as the second most important priority for Haiti after the earthquake, but it has still not been considered as a priority by the Haitian government (Henrys, 2010). However, lack of an administrative unit for Mental Health within MPHP in charge of planning, organisation and coordination of mental health services, hindered these efforts so far, and is considered as a major constraint for developing a mental health care strategy in Haiti (Bijoux, 2010). The recent appointment of a focal person for mental health in MPHP will hopefully improve cooperation and coordination of MHPS activities among INGOs, local NGO partners and the Haitian government. During the initial implementation stage, Cordaid also encountered some problems with its local NGO partners who seemed to be oriented more towards their own needs, i.e. development of their own human and material resources, than in the delivery of good quality MHPS intervention to the earthquake affected population. Douyon (2010) mentions an individualistic attitude of Haitians as one of the reasons why, in spite

of massive international assistance and the surge of international experts, there was no real progress in Haiti in the past. However, this is not in line with traditional Haitian voodoo values of sharing, community spirit and solidarity (Douyon, 2010). In the absence of a National Psychiatric Association and exchange of psychiatric practices, Bijoux (2010) also mentioned a prevailing individualism impacting the provision of mental health care services in Haiti.

Similarities and differences with other strategies of MHPS support in disaster settings

Different strategies of MHPS support have been applied in complex emergencies and after disasters, worldwide. For example, in Sri Lanka, post tsunami, the World Health Organization recruited, trained and appointed community level workers to work with affected communities (Mahoney, Chandra & Harischandra, 2006). This initiative was complemented with mental health training of PHC workers by an INGO in three districts (Budosan et al., 2007; Budosan and Jones, 2009). Somasundram (2006) stated that the training of community level workers in basic mental health, and developing a referral system in PHC was the most cost effective strategy of providing MHPS support in Sri Lanka.

The training programme of health professionals in Grenada, after hurricane Ivan, was an integrated, community based, mental health response delivered through an existing mental health care system, and was therefore substantially different from most other post disaster mental health activities delivered in Caribbean (Kutcher, Chehil & Roberts, 2005). According to the same source, most mental health interventions following disasters in the Caribbean have been vertically delivered, and are largely ineffective and costly psychosocial programmes.

In Haiti, there were also many vertical MHPS interventions delivered by different local and international MHPS players, and with no clear integration of psychosocial and mental health programming (Mental Health & Psychosocial Support Network, 2010). Cordaid's strategy tries to complement MHPS interventions within communities with mental health interventions within the health care system. According to Lecomte and Raphael (2010), basic MHPS services, although scarce, exist in Haiti, but they are not properly integrated. Since Haiti is prone to natural disasters, such as draught, floods and hurricanes, and international and national assistance is frequently impermanent (World Health Organization, 2010a), developing integrated system of MHPS support in Haiti can also serve as a preparation for new emergencies (WHO, 2003).

Lessons learnt and the way forward

According to our experience in Haiti so far, both Haitian NGOs and individuals tend to be very much concerned about their rights; they like to negotiate and renegotiate their contractual agreements. This can sometimes make it difficult to reach an agreement, particularly with local NGO partners who are solicited by various international organisations. At the same time, the output of some local organisations may not meet their contractual obligations if their activities are not properly and frequently monitored. Agreements with local NGO partners have to be done on a case-by-case basis, because there are no national rules and regulations.

Recently, Cordaid has become a member of mental health group headed by WHO Haiti. This group is in charge of mapping mental health care services in the country, and developing mental health care policy and strategy for Haiti. Cordaid has been doing

an extensive mental health care programme in Haiti, covering five out of ten administrative departments, it is recommended by the Mental Health Advisor that Cordaid shares the results and challenges of its programme with the other members of mental health group. A future evaluation of Cordaid's community-based part of the MHPS intervention implemented by trained community level workers in targeted Haitian communities is needed, to see which MHPS techniques were culturally appropriate and effective for mental health problems among Haitians.

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¹ The partner organisations included : Initiative pour le developpement des jeunes (Idejen), International Child Care (ICC), Service Oecumenique d'Entraide (SOE), Solidarite Fanm Ayisyen (Sofa), Centre de Promotion des Femmes Ouvrières (CPFO) and Caritas Haiti.

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Emergencies and disasters as opportunities to improve mental health systems: Peruvian experience in Huancavelica

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The paper describes the development of a community oriented mental health care system in the Region of Huancavelica (Peru), after a devastating earthquake in 2007. The area is also one of the most inaccessible and disadvantaged areas of Peru. Collaborative efforts by health personnel in the area, the Regional Directorate of Health and the international organization Médicos del Mundo – España, led to a wide range of activities such as: 1) the revitalisation of a dysfunctional Community Mental Health Centre; 2) the development of a Regional Mental Health Plan, through an participatory process; 3) a pilot action research project in the community to identify people with severe mental health disorders who did not receive psychiatric care; 4) the training of general health personnel in mental health and 5) support a mental health reparations programme for survivors of political violence. The authors argue that emergencies and disasters can be an opportunity for fundamental changes in the mental health care that would be very difficult to implement at other times. The first six months of reconstruction after a disaster represent a privileged time for non-governmental organisations to assess the local mental health care systems, and work hand in hand with survivors and the authorities to elaborate longer term projects and mobilise the necessary support.

Keywords: earthquake, health reform, mental health care systems, mental health plans, Peru

Background

Médicos del Mundo-España (Doctors of the World-Spain, MDM), an independent international aid organisation, has defined psychosocial and mental health work as one of its priorities. Since 1994, MDM has developed programmes in Spain and many other locations including Bosnia, Kosovo, Palestine, Sri Lanka, El Salvador, Guatemala, Mexico, Peru, Colombia and Haiti by providing support to national and regional mental health programmes, supporting local organisations working with specific groups, and developing mental health emergency actions. Over the years, the organisation has been developing a project model focused on supporting public health models and transforming the population's living conditions from a starting point of war, emergency or disaster. In the countries listed above, mental health systems are usually nonexistent or underdeveloped and therefore considered strategic by the organisation.

Aid work, in response to disasters, has traditionally placed a priority on detecting

and responding to the immediate needs of the surviving population. However, particularly in societies struck by political violence, it is also important to pay attention to structural conditions underlying the emergency, and the analysis of vulnerabilities and capacities (Anderson & Woodrow, 1998). It is also important to focus on opportunities for structural change. A crisis situation can create such a potential for change. Opportunities may arise from the need to reconstruct, and therefore, also the opportunity to re-plan and redesign interrupted or underdeveloped health care structures, as well as the arrival of external aid providing additional sources of qualified technical personnel and financial resources. This report focuses on the work being carried out in the region of Huancavelica (Peru). It briefly summarises the experience of (re) planning, and the development of the mental health care system in coordination with the Pan-American Health Organization (PAHO), national and regional government, health workers and civil society, through using the crisis as an opportunity for change. Similar approaches have been developed, or are being developed, in Sri Lanka, the occupied Palestinian Territories and Haiti.

Project context

The Huancavelica region is located in the central Andes of Peru, and is the poorest and least developed area of the country. Its population (475,000 inhabitants) is predominantly rural, Quechua-speaking, and living in scattered communities. Its inhabitants have suffered centuries of marginalisation, and ethnic and cultural discrimination. Between the years 1980 and 2000, Huancavelica was one of the regions most affected by the armed conflict between the Shining Path (*Sendero Luminoso* in Spanish), a Maoist

insurgent guerrilla organisation, and the Peruvian Government. The population suffered devastating massacres, systematic disappearances, torture, sexual violence, and forced displacement, from both sides. This war, combined with an extreme level of poverty (70% of population subsistence living) left an indelible mark on the region's people and communities, breaking down community and family support networks (Truth and Reconciliation Commission (TCR), 2003) Fig. 1.

The region's geography is very complex. Situated in the Andes, at over 4000 metres above sea level, its communities are inaccessible. There is only one asphalt road crossing north to south, and the rest are dirt tracks that are impassable in the rainy season. Therefore, significant geographical, cultural and economical barriers prevented patients from outside the regional capital to receive care. The population is widely dispersed in small communities and, above all, there are extreme levels of poverty and exclusion (Instituto Nacional de Estadística e Informática (INEI), 2010). There are also cultural factors involved, most of the population is Quechua-speaking and influenced by idiosyncratic views on health and disease, causal explanations, forms of seeking help and healing, and the importance of social and family ties in the process of falling ill (Elsass, 2001). It is not surprising, therefore, that the population does not use health centres even when available, not because they resort to traditional healing (very basic and debilitated nowadays) but because they are not used to it. They simply treat most diseases at home with local remedies (Rivera, 2003). These beliefs have serious implications for mental health care and intervention strategies.

Mental health care was virtually nonexistent in 2007, with only five psychologists working



Figure 1: Map showing violent incidences - number of official victims per region. Huancavelica: 13,523 Source: Reparations Council.

in the health or the educational system over the whole region, and a very low demand for care limited to some psychosocial problems presenting to rural health posts (family disputes caused by alcohol consumption, school failure in children, suicide attempts and teenage pregnancy). These cases were referred via primary care. The Peruvian Truth and Reconciliation Commission (in Spanish: *Comisión de la Verdad y Reconciliación* (CVR)) (June 2001–28 August 2003) proposed a Comprehensive Reparations Plan (*Plan Integral de Reparaciones* in Spanish) that was mostly not met, but that

allowed the hiring of 14 more psychologists in the region. There is no mental health care training available in Huancavelica, and those accepting work in the region have had urban training. Most professionals lack even basic skills in community intervention, preventative approaches, or inter-cultural approaches. The Ministry of Health and the international cooperation programmes have made considerable efforts in providing training, including the AMARES Project (a programme to modernise the health sector, financed by ECHO, European Union) and the Project of Comprehensive

Healthcare for People Affected by Violence (financed by the Japan International Cooperation Agency (JICA)). However, due to poor working conditions and hardship, it is very difficult for professionals to remain in the region, and once they finish their short term contracts, they prefer to go to other regions in the country. As a result, training efforts get lost again and again.

Even so, the number of professionals has gradually increased to almost 20 currently, distributed among the 51 health centres located in the region, and one mental health centre run by the Huancavelica District Hospital. Paradoxically, this marked progress in human resources did not translate to a substantial change in the number or profile of patients attending, nor did it encourage any community inclusion in decisions over future action. Furthermore, one psychiatrist spent these first years engaged in little more than administrative work. Nor did the increase in professionals lead to the creation of functional structures for guiding and lending consistency to working groups, with specified goals and objectives, and action plans based on local requirements.

In addition, there are unique problems to the development of systems. There is a lack of an integrated epidemiological and data collection system, as well as a shortage and discontinuity of psycho pharmaceuticals available to patients, caused by the lack of training of general practitioners who do not consider psycho pharmaceuticals among the essential drugs to order. In this scenario, one of the first pieces of striking data collected during the baseline study was the practically nonexistent clinical care for severe mental illness (such as schizophrenia and bipolar disorder). The regional records showed an average of 16 consultations per

year for 450,000 inhabitants, and that each year two people were admitted to the district hospital which has 108 beds. These numbers are far below what would be expected given the usual prevalence of severe mental disorders. Because there are no known indigenous healing structures for people with severe mental disorder, some thought that either there were no psychotic patients in Huancavelica, or they had been brought to other regions by their relatives, or to one of the big psychiatric hospitals in the capital Lima. It was equally surprising that there were no survivors of political violence receiving care, given the extreme severity of the problem, and despite there officially being a specific programme in place for survivor mental health recovery.

Huancavelica: a mental health care project after the earthquake

Médicos del Mundo first intervened in the Huancavelica region immediately following the earthquake of August 2007 (Rivera et al., 2008). Fewer fatalities were recorded in this region than in the coastal area, but it suffered a great deal of material damage. For more than a week, there was severe shortage of food supplies and many communities remained isolated, with no emergency support at all. The suffering of the population was aggravated not only due to the fact that this is Peru's poorest region, but also because it has been one of the most affected by the political violence during the years 1980–2000.

During this post earthquake phase, Médicos del Mundo focused its intervention on reconstructing eight health care facilities (*centros de salud*) and identified the need to support the small, local mental health team working in the emergency. An MDM team supported the professionals, and while working with

them it was discovered that no mental health care facilities were available in the region. The regional authorities were concerned as a result, therefore, the occurrence of earthquake helped to add mental health care as a priority to the health agenda. MDM organised an initial participatory assessment with social organisations, institutions and professionals. The aim of this was to introduce the idea of a joint effort to review the situation of mental health care in the region, and to draw up initial ideas on what kind of a regional mental health system could encompass all the main stakeholders involved in the health and social sector in the region. It was a strategic moment, as at the same time, the Peruvian government was implementing an extensive decentralisation policy and gradually transferring control (and budgets) for health care to the regions. Two three-day seminars were developed, jointly led by MDM and the head of the mental health unit of the local Health Directorate. The plan of action was then negotiated with the health authorities to ensure technical, administrative and political support to the process. In November 2008, one year after the earthquake, a collaboration agreement was signed between MDM and the regional government of Huancaavelica, the Regional Health Directorate and the District Hospital, with the backing of the Ministry of Health, and the Pan American Health Organisation (PAHO). This signalled the start of a project of redesign and improvement of mental health care within the framework of strengthening the structure of primary health care services. Between June and September 2009, baseline studies were conducted on: (a) lay perceptions of mental health and priorities (15 focus groups in different areas of the region); (b) statistics of use of services; and (c) perceived needs

and proposed solutions, especially those of professionals working in remote rural areas. It was discovered that neither the population, nor the professionals, could clearly identify mental health problems. The priorities were domestic violence, linked to alcohol abuse, the abandonment of old people (some of them literally dying of hunger), and conflicts and lack of solidarity attributed to the war. Health professionals could identify somatic and anxious disorders, but they did not consider depression or schizophrenia a problem worth mentioning. The statistical data also showed that there were apparently no cases demanding attention, and therefore it was not considered a priority in policy planning by local stakeholders. The project did not start until January 2010, due to difficulties in finding donors. Funding has always been short term and unstable, which has had a negative impact on the dynamics and feasibility of substantial elements of the work. Even so, the project focused on the creation of a mental health care system in an integrated and participatory way, under the coordination of the Regional Health Directorate, and with the collaboration of various levels of local health workers.

Project model

During the acute phase of the emergency

The initial focus of the MDM approach systematically avoids individual or group clinical intervention with survivors based on the idea of trauma, and instead favours community mobilisation. This allows the population to regain control over their lives as soon as possible, and to be actors in their own process. To that effect, MDM-Spain has found, since 2007, that the *IASC guidelines* (IASC, 2007) are a useful framework for reference that is in line with the strategic outlines traditionally developed by the organisation. MDM aims to: (1) support

inter-institutional coordination mechanisms (including local authorities, where the political and human rights background allows); (2) act through reinforcing community response, and strengthen collective resilience through community mobilisation and participatory tools appropriate and adapted to the political context, capacities and culture; and (3) intervene by connecting, from the first day, the emergency with the subsequent process of reconstruction, helping people to work through their own vulnerability capacity analysis. When MDM chooses to go to an emergency, this is usually associated with an initial commitment to remain for 6 to 12 months, to be extended if there is the possibility of supporting processes for consolidating public mental health care service systems.

From the acute phase to transformation

In general, in abandoned areas, disasters can create real opportunities for change. It is important to bear in mind, in the initial assessment, how to unite the crisis to the post crisis, in one shared, common framework. What happens in many situations, when most nongovernmental organisations (NGOs) are purely focused on emergencies, they leave, and then people and communities are generally forgotten and end up in a more vulnerable position than before. This requires an intervention during the emergency that does not replace nor compete with the public health systems in mental health care, but tries to see the emergency as an opportunity to reinforce and complement them on a temporary basis, and to set a framework for further development. In many situations, this is also an opportunity to introduce new ideas and proposals regarding integrated clinical and community care that goes far beyond what the state usually provides.

After an initial assessment, some initial ideas can be drafted with local authorities and civil society. This also entails preparatory work, whereby certain agreements are signed for the transfer of any new services to the public health network, in order to ensure as much as possible, future sustainability once the NGO leaves. Consequently, the services developed will be in tune with the design of the overall health strategy and the National Mental Health Plan. In some contexts, this will already exist prior to the crisis, and in others the World Health Organisation (WHO) or PAHO will be in the process of collaborating an agreement with the Ministry of Health (MoH). In other cases, no such groundwork will exist, and therefore it will be essential to recommend that this work on an integrated plan be carried out.

For this reason, MDM collaborates with other national and international organisations and authorities, to help create the conditions for executing a national plan. This is done in collaboration with the health authorities and public institutions, and social and human rights organisations working in mental health and psychosocial fields. It also includes the general population, particularly service users, as they are usually excluded from the process. This is usually done using a bottom-up strategy, involving community leaders, to define what mental health is, and what the priorities should be in a policy plan. This works simultaneously with a top-down approach that collaborates sensibilities and joint efforts at all levels of the health care system. In those contexts, where national health plans do not allow for a comprehensive approach (e.g. progressive reform of psychiatric hospitals, systems integrated with the basic health service network, etc.) it is hoped that working within a network will promote a review of processes with

authorities and actors involved. In this way, we move in the long term towards models of comprehensive psychosocial and community services in the field of mental health. The objective is therefore to be able to jointly assess the system of mental health services in the country or region that is suffering the crisis, working in collaboration with the Ministry of Health, United Nations agencies, major mental health focused NGOs involved in the crisis, and the actual people affected.

Helping people to review a current mental health system, and what would they like it to become is not enough without also having a commitment to develop substantial parts of it. One possibility is to look for different NGOs, who can assume different parts of the intervention. However, it is usually better for each NGO to assume the development of a full system within a region, including all the specific difficulties and shortages. This includes systems of exchange and coordination that allow for mutual reflection and education through the implementation of the plan in each area. Each context requires specific and careful analysis tailored to local circumstances.

For example, it is not possible to compare the factors at play in a country like Sri Lanka, with those in Palestine, or Haiti. In Sri Lanka, the following conditions exist: mid income, political willingness to implement a process of reform, minimal number of professionals, and a five-year plan developed as collaboration between the government and the WHO. Whereas in Palestine the situation is: low income, high number of professionals, many political actors with different political attitudes in regard to the authorities, and a five-year plan developed with the WHO. While in Haiti it is: very low income, complete lack of professionals, predominantly private medicine or provided by charities, no plan, and almost complete absence of resources to fund any proposals (Figure 2).

From planning to action in Huancavelica: several areas of work that were addressed simultaneously

- Peru has a National Mental Health Plan, but is far from responding to the specific needs of the Huancavelica Region. Developing the Regional Mental Plan through an extensive participatory process driven by MDM and the Regional Health authorities was one of the main objectives

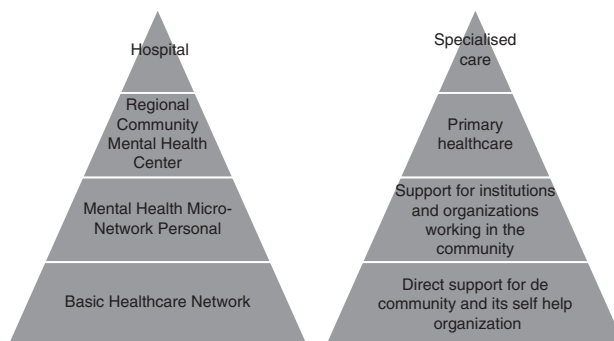


Figure 2: Proposed structures and levels of care.

Source: Independently produced.

of this project. The final document is a comprehensive five year plan, with six different areas, and 22 objectives ordered by priorities and levels of responsibility, of each stakeholder in the health care sector. At the time of writing this paper, the final drafts were under discussion and refinement.

- Redesigning, extending and equipping the Community Mental Health Centre (CMHC) run by Huancavelica District Hospital. This was an old building, attached to the hospital that had to be rebuilt. It is now a refurbished two floor building that includes three outpatient consultation rooms for adults and children, a room for training workshops and group therapy, a small addiction unit in the basement, and a kitchen. Additionally, there are two small rooms for relatives of psychotic patients admitted to the hospital who must travel long distances, and for community health workers staying in town. The CMHC is designed to meet the clinical demand in town, while creating a regional centre of technical reference with the ability to formally train, supervise and enhance the performance of mental health care workers and the health teams scattered across the region.
- In Huancavelica, the health system does not attend people with serious mental disorders. Additionally, although victims of political violence are considered a priority, they are not reached by the system, as far as there are no proactive activities to the rural areas where most of them live. Also, for many cultural and community reasons, people affected will not go to the health centre to consult for their mental health symptoms. A pilot action research has been completed for the detection of the hidden population of patients with unmet needs. There was

the hypothesis that there was a large, hidden demand for both populations, and the challenge was to uncover it with the few resources available. So, three areas were chosen for a pilot action research. This means that the team was doing a *research* on prevalence of mental disorders, but at the same time this was done hand-in-hand with the community. The patients detected were enrolled in a case management programme with the nearest health centre (*action*). Theoretical research was applied to action, involving those supposedly the subject of the research. This research has been done in three pilot areas. Two groups of four local health workers, using a standard protocol, have gone community by community, talking to community leaders, and religious and social authorities and neighbours. The team approached patients, relatives and neighbours in a nonintrusive way. It should be pointed out that in the first week of working with informants from just one of the 27 micro-networks (the base administrative structure of the Peruvian health system) around the region, 13 severely psychotic patients were found in conditions of semi-abandonment, or confined to the home. This is more than the number of patients seen in the last five years in the District Hospital. At the end of the first two months, 60 severely psychotic patients, most of them already diagnosed at some point in their lives, were left untreated, and with no access to proper care. This was an unexpected and surprising result for the local team and an important revelation. A second action research, following a similar methodology, explored the needs of survivors of political violence with severe psychological problems. The team asked, in each community, for people officially

recognised as a survivor by the TCR. They then searched for other survivors, using a snowball sampling methodology. The team conducted individual interviews, not focused on trauma or symptoms, but on overall health (including mental health), life in the community, needs and expectations. In the context of extreme poverty, such as in Huancavelica, the results showed that the survivors were worried because they had not received economic reparation, in spite of all the intervening years. They asked for psychological support, but in truth were much more interested in being helped to get their small funds paid. These two populations, those with mental illness and survivors of political violence, will become initial priorities of future training programmes for psychologists within the micro-networks. The next action researches considered for the immediate future will include suicide and alcoholism. This is because alcoholism is extremely common in the region, and the basis of sexual abuse and domestic violence. These two topics will be based on a completely different methodology, more grounded in qualitative and anthropological methodologies. The health authorities are designing an information system that will specifically collect data for building a system of continuity of care for severe mental disorders.

- The training of health personnel has begun slowly in a pilot micro-network (Angaraes, 60,000 inhabitants). It is based on bringing professionals from other regions that can train in clinical and community care, by means of supervising complex cases, and training based on actual situations brought in through participants from their daily work. The training also includes working with

communities severely affected by violence to do self-assessments, using action research principles. The aim is to generate processes of collective strengthening in communities affected by poverty and violence. It is hoped that the psychologists will be able to create self-managing community psychosocial processes.

- The programme includes support for associations of survivors of political violence and the Regional and Provincial Reparations committees, in order to strengthen human rights initiatives. There will also be exhumations of mass graves in the region in the near future. The local mental health workers will receive training in the International Standards for Psychosocial Support in the Search for the Disappeared (Navarro-García, Pérez-Sales, & Fernández-Liria, 2010).

Future steps

Overall, the future is uncertain. Despite the political agreements that have been signed and the consensus regarding the mental health care plans, elections can bring radical changes. This was the case in Huancavelica in 2010, and in 2011. The new authorities promised to respect agreements and provide full support to the process. However, despite these promises, the Peruvian government has introduced new budgetary management systems based on Results Based Financing (RBF, a financial strategy that attempts to provide estimates in terms of concrete results). This has brought chaos to mental health planning. RBF attempts to assign resources based on patients attended, severity of diagnosis, average length of each intervention and so on. These sorts of estimates are almost impossible at the present time as there are no structured, basic mental health services. The criticisms and confusion

resulting from this has now created a question on the whole model, and the future of budgetary assignments from Lima remains uncertain. This kind of policy planning, perhaps appropriate for other fields of medicine like surgery or orthopaedics, is more geared towards closed clinical diagnoses and expected expenses that can be attributed to patient and diagnosis are difficult to fit into the psychosocial context. This kind of budget by results carries the risk of limiting the effects of the reforms achieved thus far, unless there is more flexibility. For this reason, it is a key for the future to maintain the participatory nature of all the process until now. This will ensure that, beyond the transfer agreements signed by the authorities, the situation cannot easily revert because there are lasting changes in team structures and perspectives for their objectives and work. In this way, a broad base of social and citizen participation, which will support the changes, will be created.

Lessons and suggestions

Many lessons have been learned in these three years since the earthquake, and these are discussed below.

1. *The importance of prioritising the strengthening of mental health services within the public health system.* Peru is making a significant effort to develop free healthcare programmes and a mental health care programme must have a place besides the more traditional health objectives of prevention of maternal mortality, vaccinations, and child nutrition. The situation generated by the earthquake helped to find receptive and favourable political authorities. Although, for the moment, these programmes are limited to illnesses and disorders defined in the national PEAS (*Plan Esencial de Aseguramiento en Salud*, or Essential Health Insurance Plan), which does not include mental health. However, the majority of trained health workers in the centres and networks are keen to expand their knowledge and skills in this area, and to push for its inclusion in the PEAS in the future.
2. *The value of designing intervention plans locally through participatory processes involving all actors.* The different regions of Peru vary enormously from one to the next, and therefore the National Mental Health Plan and central government guidelines cannot be applied directly, without recognising the particular characteristics of each area and the existence of local institutions and actors. At the same time, the local perspective is enriched by, and benefits from, being integrated into the national and international context, particularly in terms of the guidance and support offered by PAHO.
3. *One of Huancavelica's particular challenges is its extensive and extreme geography, problematic means of communication and dispersed population.* For this reason, innovative systems are required. The proposed plan would create a network of small units, with little or no dependence on central structures, particularly the hospital, and within which there can be a regional centre acting more as a technical and training consultant, than a clinical reference point. The organisation cannot work as a pyramid of services of increasing complexity and systems of screening and referral among levels. It must be closer to a horizontal multi-nodal system.
4. *The survivors of political violence appear in all political declarations by authorities, but are in fact excluded from the health agenda,*

despite the existence of specific resources and budgets from the national reparations programme. This can be explained by a number of factors, discussed below. 1) On the one hand, the very nature of the damage of political violence, which includes fear, lack of confidence, polarisation and isolation, dictates that the programmes must be proactive. There is not much sense in waiting for the survivors to come to some kind of specialised facility. 2) In addition, there is a lack of specific training for health professionals, aggravated by the constant rotation of staff that prevents the personnel from establishing bonds of confidence with the survivors. It is necessary to put a lot of emphasis on rectifying this situation. Health professionals are not trained to be proactive in their work, but tend to wait for patients to come. 3) The government is now offering economic compensation far below what was promised three years ago, before elections, thus limiting access to health and mental health care, and increasing distrust towards any one working in the public sector.

5. *The method of detecting severe mental illness by proactively entering communities, and using key informants and snowball sampling methods, proved to be an extraordinarily effective strategy.* The authors have advanced some data here. The process and detailed methodology and epidemiological findings will be published elsewhere. However, such an easy, cheap and direct intervention has proven to be more cost efficient, feasible and respectful to patients and communities than the more sophisticated methods of two-stage screening using door-to-door, semi-structured interviews. Although

we cannot detect all cases, it is possible to make an initial case register in a short time without using extra human resources, and begin to change stigma and marginalisation by spreading the word that there is treatment for severe mental illness, and that the health care system can help in providing it.

Conclusion

The authors have presented an outline of the implementation and progress of the Regional Mental Health Plan in Huancavelica (Peru), in order to demonstrate that an emergency intervention, following the earthquake that devastated the centre of Peru in 2007, can become a catalyst for change. NGOs should be able to work, not only based on an immediate needs assessment, but also by keeping an eye on structural vulnerabilities. It is important to have an historical long term view that understands that there is a past of poverty, war and violence and that there must be a future. It is possible to create a development project in a short time, taking advantage of the great amount of funds that emergencies usually raise. The emergency funds, lasting approximately a year and half, allowed the reconstruction of part of the physical infrastructures that were damaged, and built new ones. Instead of substituting or competing with existing structures, the initial six months of reconstruction enabled an analysis of the previous mental health care system, and allowed for designing alternatives to reinforce it, in collaboration with technical staff and local authorities. Importantly, the project was designed as a participatory process that departed from the perception of needs by the survivors, and agreements with authorities. The crisis was the opportunity for change.

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Takamol: multi-professional capacity building in order to strengthen the psychosocial and mental health sector in response to refugee crises in Syria

Constanze Quosh

The massive influx of Iraqi refugees into Syria in 2006 put an immense strain on the already under-resourced mental health sector. This prompted a consortium of international agencies to create an Inter-agency Working Group (IAWG) in 2008, with the goal of national capacity building. This Inter-agency Working group merged into a National Advisory Board that included the Syrian government. An integrated one-year master training programme for mental health professionals was designed. The first cohort of master trainers successfully completed the programme, and started to train frontline worker with very good results. There has been widespread advancement in awareness of integrated psychosocial and mental health approaches, multi-professional teamwork and training methodology among practitioners. This has translated into practical projects improving the quality of care for beneficiaries. In addition, comprehensive training curricula and a bilingual handbook have been drafted with the goal of integrating and streamlining psychosocial, mental health and training methodology. Initial steps have also been taken to create a unified National Mental Health and Psychosocial Council.

Keywords: capacity building, mental health, Middle East, psychosocial support, refugee, Syria

Background

The war in Iraq triggered complex emergencies in countries throughout the region as a

massive influx of refugees spilled across its borders (Figure 1). Syria received the largest number of refugees, and although notable in its generous and lasting asylum policy, it is now finding its infrastructure, and in particular, the public health systems strained.

Iraqis who remain in Syria are particularly at risk; many are unable to gain resettlement to a third country¹ or to return home. Quickly diminishing resources and a lack of prospects for the future have had strongly negative effects on the refugee population, such as: deterioration of living conditions, day-to-day stress and uncertainty that compounds past distressing experiences that caused their flight from Iraq. Changes in roles and belief systems have been profound, contributing to increased domestic violence and survival sex. Many refugees had arrived expecting a temporary stay, but find themselves in 'protracted stasis', without the ability to make future plans. As financial difficulties have worsened, assistance has waned and treatment needs go unattended, it is expected that social, health and psychological problems will escalate (Le Roch et al., 2010).

Therefore, while the situation in Syria can no longer be considered an acute crisis, it is certainly a complex emergency² that has developed into a protracted refugee situation.³ Although desperate, the conditions also provide an environment for innovative

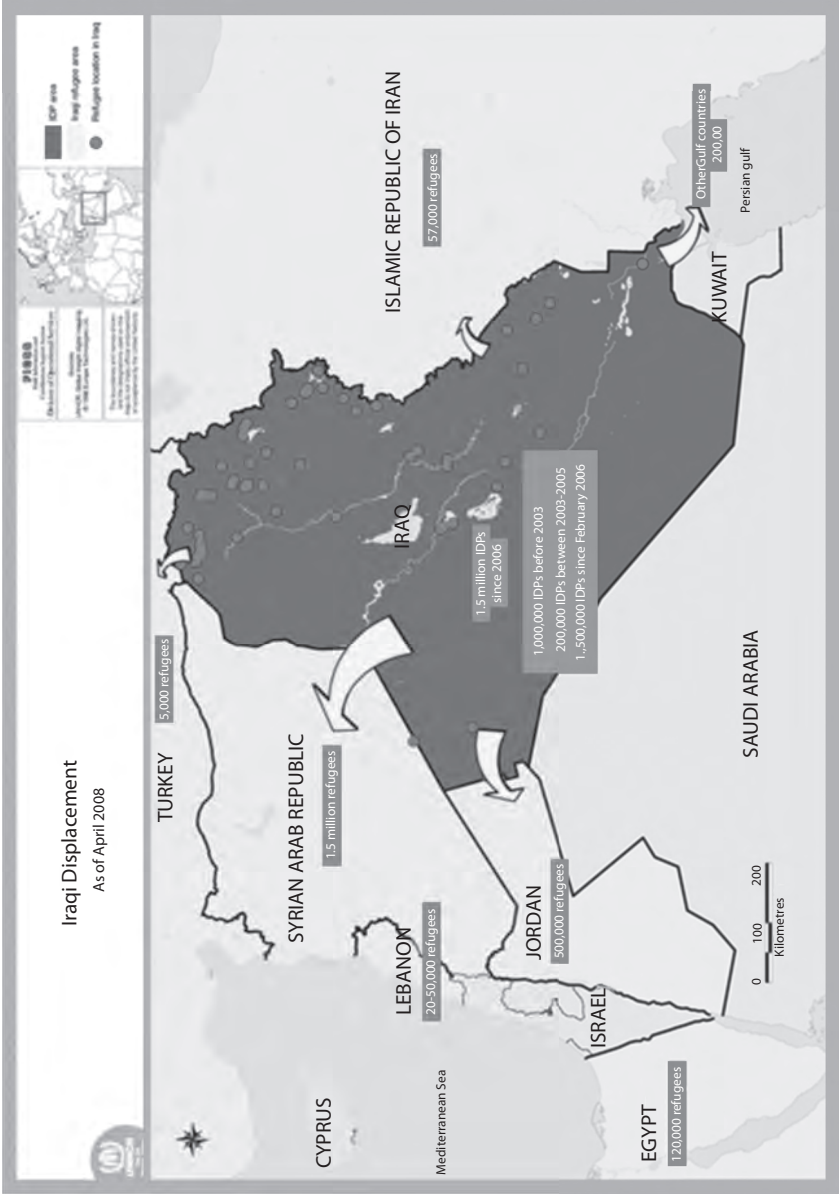


Figure 1: Map with United Nations Commissioner for Refugees estimates of Iraqi Displacement in the region. Source: Map 1: <http://www.unhcr.org/487e7144.html>.

response; channelling available impetus and funding towards transition from humanitarian aid to more sustainable development programmes.

For the most part, Iraqi refugees in Syria occupy an urban refugee setting (Figure 2), which differs sharply from camp settings and presents certain unique challenges; most notably difficulty in identifying persons at risk, who are in need of support or specialised care, and providing access to adequate services. This makes community-based outreach crucial, and requires an efficient referral system.

Although regionally there are a number of humanitarian organisations operating, there are only a limited number of international and national nongovernmental organisations (NGOs) active in Syria. For this reason, the Psychosocial Support and Mental Health (PSS MH) programme for refugees is currently primarily implemented by UNHCR. However, intensive capacity building, occurring within the different levels of the public health systems and social services, will pave the way for a responsible transition to national organisations.

Mapping the context: mental health in Syria

Understanding health and illness in the Middle East is impossible without linking it to the local context. Mental health care in Syria is still developing. Currently, for a population of 21.8 million (World Factbook, 2010), there are 89 psychiatrists. This is a ratio of approximately one psychiatrist to a quarter million people. The estimated minimum ratio by WHO is 25 times that amount, approximately one psychiatrist to 10,000 people (MHWAC, 2008). An accurate measurement of psychiatric morbidity in Syria is difficult to estimate due to the lack of data, and the wide-ranging effects of high levels of social stigma associated with mental health issues. This also prevents accurate reporting of diagnostic and other mental health statistics. Overall in Syria, support is medicalised; provided by psychiatrists with a clear dearth of community based services. Aside from resulting in an intervention-focused, overburdened and less efficient system, the lack of prevention efforts and formalised community care is problematic as modernisation has begun to erode

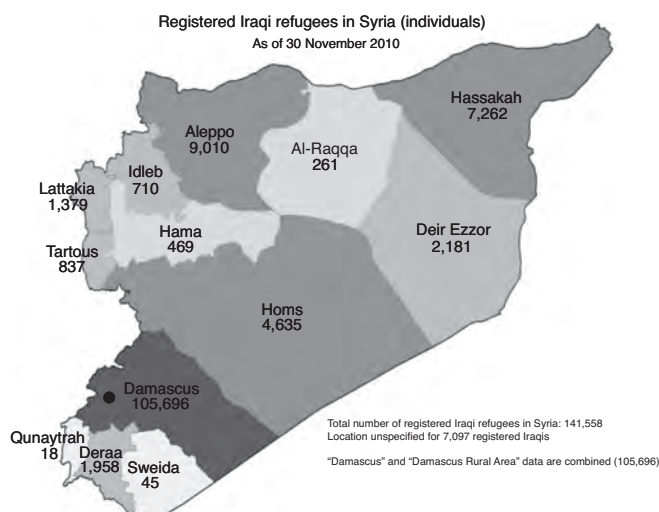


Figure 2: Map with UNHCR estimate of registered Iraqi refugees in Syria. Source: <http://ochaonline.un.org>.

community support systems, particularly in urban areas.

In the mental health sector, the dominant area of study and practice is general adult psychiatry, taught in the medical school and designated by the Ministry of Health. There is no formal clinical psychology education or therapy training, as programmes are conducted through university faculties and concentrate on counselling, without formalised field experience. These educational differences, as well as formalisation (e.g., lifetime psychiatric licensing, vs. no legal framework for licensing psychologists) and perceived status distinctions between doctors and other mental health professionals make the professions notably hierarchical. This results in a lack of cooperation between services and support levels, and offers little integration between psychosocial support and mental health care. Furthermore, training methods and services in the sector are spread across four Ministries: Health, Education, Higher Education, and Defence. This fragmentation results in inconsistent instructions of varying quality. This is also compounded by the striking lack of updated written materials in the region. Education in the sector is largely medicalised due to the stronger presence of psychiatrists and, in part, easy access to inexpensive medications. Additionally, the strong social stigma impedes seeking help among clients, until a situation becomes acute and hospitalisation is necessary. Further adding to the problem, psychiatric hospitals are large and institutionalised, with very few integrated day programmes and no ability to follow up patients once they have been discharged. This often results in relapse.

Needs assessment

In line with the lack of mental health research in Syria, there are very few

studies concerning the situation of Iraqis in the country. However, supplemented by research conducted in the region, there is a clear indication that the context within the country results in numerous psychosocial stress factors.

Studies on refugees in Syria indicate that families remain isolated, as primary social networks were lost in displacement (Le Roch, et al., 2010; Ventevogel, 2008). Family members, particularly youth and women, spend much of the day inside their homes, compounding their sense of isolation and grief, and reducing their ability to locate and develop sources of social support (Gilbert, 2009). De-professionalisation, in the sense of loss of, and lack of, opportunities for professional occupation, as well as the need to readapt to new social roles in the current environment, were cited as main stressors by 33% of one study sample (IOM, 2008). Both men and adolescents express feeling '*not useful in society*' (Jayawickrama & Gilbert, 2008). The insidious shift in family structure occurring as a result of displacement, and the inaccessibility of work for men is causing fundamental role changes, resulting in a steep rise in domestic violence among refugee households (Le Roch, et al., 2010).

Anxiety and depression are the two most prevalent psychological symptom clusters experienced, with estimates ranging from 42% among samples of Iraqi refugees (Duncan, Schiesher & Khalil, 2007) to above 80% (UNHCR, CDC, 2007). Symptoms reported to psychologists include specific phobias, nervousness and anxiety in adults, and aggressiveness and withdrawal in children (Le Roch, et al., 2010), with girls tending to be more isolated and withdrawn, and boys tending towards disruptive and aggressive behaviour (Tsovoli, Coutts & Quosh, 2010). Gender differences among adults are also

commonly found, with women evidencing significantly higher rates of affective disorders (WHO, 2009; Duncan et al., 2007) and middle-aged and older men trending towards higher rates of anxiety disorders and posttraumatic stress disorder (PTSD) (WHO, 2009). Age differences are also apparent in the data, showing general mental health scores deteriorating with age, and individuals over 65 consistently reporting higher rates across symptoms, including severe depression and PTSD, indicating reduced resilience (WHO, 2009). Somatisation of stress has led to increased health care needs of the refugee population which, in combination with stigma, brings beneficiaries to general medical centres more often than directly to specialised psychiatric services. Psychosocial difficulties experienced by refugees in Syria have steadily increased due to deepening socio-economic vulnerabilities and prolonged uncertainty. Psychological stress and desperation have intensified as the length of stay has increased (Duncan et al., 2007). The oppressive climate often makes it impossible for displaced Iraqis to address traumatic events that occurred prior to, or during, their flight.

Takamol: UNHCR's psychosocial support and mental health programme

Due to the combination of overwhelming need and a scarcity of qualified professionals and implementing partners, UNHCR established a pilot PSS MH Programme, under the name *takamol*, which is an Arabic word meaning 'integration' or 'complementing'. The programme adopts a three-fold approach:

- 1) A national capacity building project;
- 2) Case management for people most at risk; and
- 3) An urban outreach volunteer programme.

These three components are heavily inter-linked, informing each other and functioning jointly. The psychosocial framework holds, as its primary focus, the interaction of psychological and social wellbeing, emphasising a process model and the interrelationship between factors in the social and cultural environment and psychological symptoms. The resulting methodology works towards developing and reinforcing existing resources in order to enable sustainable solutions in challenging environments.

Capacity building

During and after a complex emergency, the level of psychosocial distress is high. In the realm of PSS MH, reliance on specialist care, particularly in the developing world, is inadequate. Across the reviewed studies (Le Roch, et al., 2010; Gilbert, 2009; WHO, 2009; IOM, 2008; Ventevogel, 2008; Duncan et al., 2007), conducted in Syria and regionally, the primary recommended responses were strengthening the national healthcare system and enhancing its ability to respond to the needs of both the refugee and local populations through extensive capacity building.

With capacity building we mean more than improving resources such as knowledge, skills and competencies of individual trainees within a system or institution, but we also indicate facilitating relationships between institutions and sectors, and fostering multi-professional teamwork and advocacy. Despite the education based core of capacity building, an effective programme must also initiate a change in *attitudes* and *approaches* at all levels: policy, institution/professional, community, and individual. Ideally, this comes with networking and advocacy for legal and regulatory changes.

However, the currently existent systems are highly centralised and do not have the sufficient resources to attend to a suddenly

exploded morbidity in the population. Therefore, the most practical way to address the service gap is to train frontline workers to an international standard, and in a context sensitive way. This paves the way for the change in approach required; moving populations in need of support from professionals to frontline services, decentralising skills and improving referral mechanisms to ensure that beneficiaries are recognised and receive the level of care they need.

Project description

The project aims to not only improve service provision for the immediate emergency situation, but to go further using a multi-level, multi-professional approach to encourage cooperation and service integration, thereby standardising training in the sector. This will increase the number of qualified practitioners and ensure sustainable capacity. This will strengthen national services, including: primary health care centres and clinics (public, inpatient and outpatient); private psychosocial facilities; community centres; and school health and social counselling services. In this way, the project envisages a shift in approach from a relief-focused operation to a comprehensive development approach, benefiting both the displaced and national populations.

Project board

The project was initiated by an Interagency Working Group (IAWG), composed of international aid organizations involved in psychosocial support and mental health care⁴ at the end of 2008 while preparing a mental health and psychosocial sector strategy for the Consolidated Appeal Process, which is the process and tool used by host governments, UN agencies, donors and aid organisations for coordination, strategic planning, monitoring and

fundraising for humanitarian activities. The initial goal was to unify diverse, uncoordinated initiatives; however the process at that time excluded national stakeholders. Therefore, a Syrian Advisory Board was founded in 2009, involving experts and decision makers from the Ministries of Health and Education, as well as the University of Damascus and the Syrian Arab Red Crescent (SARC). Many of the advisory board members are practicing psychiatrists, psychologists and social workers. The specialised expertise of this board is a fundamental component in ensuring the comprehensiveness and context sensitivity of the project.

After the first project steps were implemented, the IAWG and Syrian Advisory Board merged in 2010 to form the Project Board, reinforcing Syrian ownership as a core principle of the project. The board is co-chaired by UNHCR and the Ministry of Health. Its role is to act as the central entity to facilitate cooperation and coordination between all stakeholders involved, including the nomination of Master Trainers (see below), recruitment for, and organisation of, frontline worker trainings (FWTs), and liaising between the board and applicable national bodies.

The cascade approach

Specialists in Syria were over-burdened, but did not have the tools for burden sharing. Recognition of this need, and an opportunity to solve this, provided an incentive to participate in the training of trainers.

The constraints inherent in the local context required an application of the cascade approach (Figure 3). This methodology uses available human resources to propagate knowledge throughout the levels of service provision. Professionals are trained as trainers and, in turn, train lower levels of service providers according to assessed knowledge

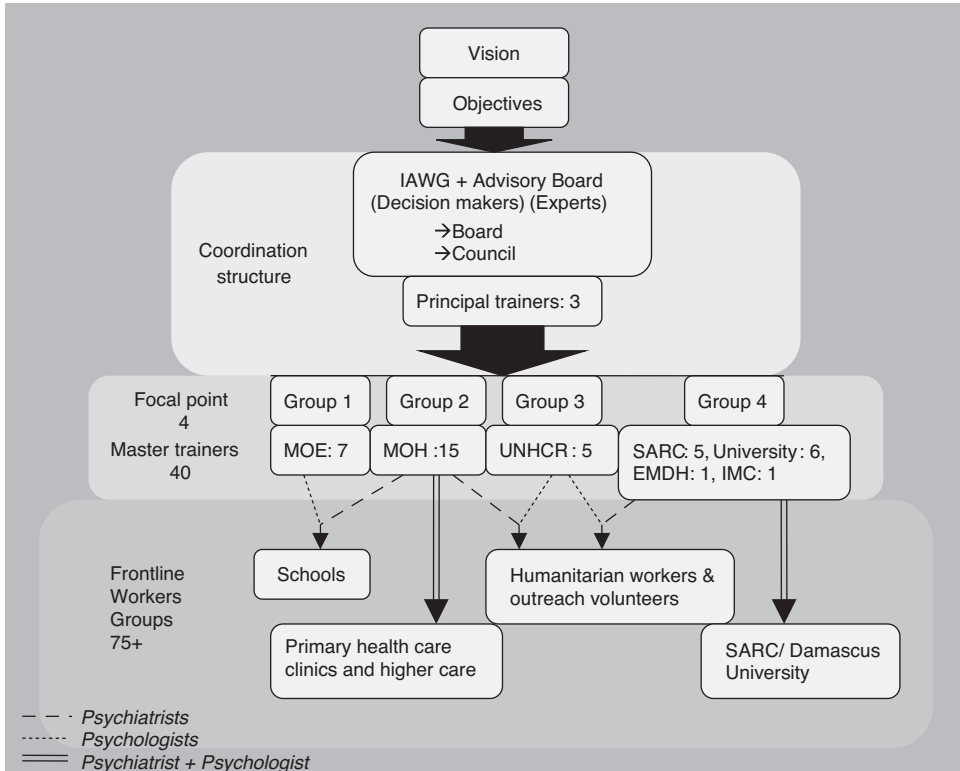


Figure 3: Cascade flow chart.

gaps. In this way knowledge is maximised with limited resources (Mpabulungi, 1999). The points of criticism regarding ToT models such as required qualities of trainees and trainers, questions of sustainability and impact if follow-ups, supervision, monitoring and evaluation were not given over a longer period of time were all considered in the project planning. (Aarts, 2010, 42) The appropriate selection, preparation and high quality implementation that used cascading with a longer term follow up eased the burden on the Syrian system.

Beneficiary groups

The project designated three levels of beneficiaries (Figure 3). The first includes: master trainers; senior psychiatrists, psychologists and social workers, who, after

the master training continue to conduct subsequent trainings. The second are four frontline workers groups operating in areas with increased refugee presence:

- 1) Primary health care services
- 2) Schools
- 3) Humanitarian workers and community outreach workers
- 4) Specialised secondary health and other services (e.g. SARC multidisciplinary units and university psychology lecturers).

These groups have received training from the master trainers, and are able to implement their skills across their service populations. The final group consists of the general population in need of psychosocial support.

Project outputs

There are three target outputs for the capacity building project:

- 1) Comprehensive bi-lingual training materials and a draft *PSS MH Handbook*, tailored to the Syrian context and capable of being used as a teaching guide for local professionals;
- 2) A cohort of 25 to 30 committed master trainers, from varying professional backgrounds, able to implement FWTs in PSS MH as multi-professional teams at the different frontline service levels;
- 3) A series of abbreviated, customised curricula targeted at the four primary service fields for use in FWTs.

Handbook and frontline training guides

The Middle East and North African (MENA) region in general, and the Syrian context in particular, suffer from a lack of available materials guiding best practice in PSS MH. Therefore, the project spearheaded an initiative to draft a handbook and training curricula accessible to professionals, detailing a unified, multi-professional system of care that is both compatible with current international standards (IASC, 2007; WHO, 2010), and tailored to the particulars of the Syrian context.

A participatory approach was taken in the development of the handbook, and included a comprehensive needs and capacity assessment, a first review process by 25 national experts and an international review process with 20 experts. Despite being criticised for its large volume, during the local field test in the master trainings, the second draft revision of the handbook was acknowledged (both in focus groups and by feedback questionnaire) as a useful and appropriately

comprehensive tool by the targeted professionals. The upcoming final revision will be undertaken at an international and national level, for both English and Arabic versions, along with extensive parallel contextualisation work (including local case studies, context sensitive translation adjustment, regional data).

The handbook draft materials are the basis for the master trainings. The main authors of the handbook, a German-Jordanian clinical psychologist and a Jordanian psychiatrist, work multi-professionally themselves, and were the principal trainers for the master trainings. This ensured consistency between the material and the trainings, and allowed for feedback and revision during the process.

Training of trainers

The training of the master trainers was based on a qualitative (focus groups, individual interviews and field visits) and quantitative (baseline survey) training needs assessment done throughout the public health and social services sectors. The resulting curriculum integrates complementary theoretical and practical components, designed to update practitioners' knowledge, promote an integrated PSS MH approach, and enhance training skills with a heavy focus on strengthening cooperation and multi-professional teamwork in the field.

Training structure

The master training consisted of an introduction day, six modules, an exam period and a certification day (Figure 4). It is a one year programme, with one module of 3–4 training days each month, totalling over 170 training hours. The first training cycle ran from December 2009 to November 2010. The full content of the handbook, including theoretical perspective and

	Module 1	Module 2	Module 3	Module 4	Module 5	Module 6
MH care	Depression	Anxiety disorders	Specific disorders (e.g., PTSD, OCD, bipolar disorder)	Psychoses	Mental disorders in children	Specific disorders (e.g. substance abuse, the elderly)
PSS	Introduction; Psychological first aid; Community-based PSS; Stress and trauma in children	Models of psychological health and suffering in children and adults; Stress and trauma; Refugees	Basics of counselling ; Special issues: torture, rape, domestic violence	Helping the helpers ; Credibility assessments	Understanding children with special needs ; Counselling and PSS through schools	Integration of PSS and MH interventions
Skills training	Basic communication skills ; teamwork ; basic training strategies	Interviewing – comprehensive assessment of bio-psycho-social situation; Basic training strategies	Bio-psycho-social case management; Assessment of training needs of frontline workers	Managing professional stress and burnout; Peer support; Planning a training session	Training evaluation, planning and observation; Team teaching	Planning a series of 3 training sessions for service providers; Team teaching

Figure 4: Training module content overview.

methods, was divided into six modules; each one with a mental health component, a psychosocial component and a training skills component. The final module tied themes together; reinforcing good practice in applied training designs, and an integrative approach.

Importantly, the training modules utilised professional adult education techniques, including experiential learning (learning through doing) and peer learning (professionals teaching their specialties to their peers for mutual mastery).⁵ All of the master trainers trained together, cross-professionally.

For the practical aspect of the training, the master trainers were divided into 20 teams of two, for support and to practice multi-professional teamwork. Each of these teams provided trainings to selected cohorts of frontline service providers in the four, previously mentioned, fields. Trainings were

based on training needs assessments done with each professional group, and served to develop the standardised curricula.

Each team conducted a supervised three-hour FWT session between modules 5 and 6. In addition, each team was responsible for a four hour FWT session (two hours per trainer), evaluated for certification. Within one year of graduating, every master trainer is required to provide five additional supervised FWTs. The supervised implementation of these trainings, including continued evaluation has begun, and will be implemented throughout 2011.

Trainer profile

The Project Board developed a set of criteria guiding the selection of master trainers. These included a minimum of five years' work experience in mental health and psychosocial support with refugees as well as training experience. A total of

44 master trainers were nominated from the Ministry of Health, the Ministry of Education, the University of Damascus, the Syrian Arab Red Crescent, UNHCR, IMC and EMDR (19 male, 21 female; 12 psychiatrists, 28 psychologists and social workers). The majority of the nominees worked in the urban centre of Damascus, however, there were also several from governorates across Syria.

Evaluation

Training evaluation

Master trainers were evaluated along three criteria:

- 1) Development of their knowledge base, evaluated through periodic multiple choice testing after each module. The final exam was in short answer and case study format.
- 2) Practical skill development, evaluated through their performance in certification trainings.
- 3) Training programme adherence, evaluated through attendance and motivation.

Knowledge tests

The total results of the knowledge tests show that all of the master trainers passed the 70% cut-off point, meeting the programme outcome goal. The lowest average score on the knowledge tests overall is 37%, and the highest is 91%. Notably, over the course of the modules, average knowledge test scores increased across master trainers, by an average of more than 10%.

The pattern of improvement across psychosocial and mental health modules is similar, although mental health had a higher baseline and generally higher averages throughout. Master trainers reported that the mental health concepts were easy to understand, reflecting the medicalised education

and service systems. It is interesting to note, however, that while the multiple-choice module tests often demonstrated a stark difference in total scores between psychosocial and mental health tests, the case study based final exam only varied by approximately 3%. This suggests minimal disparity in applied knowledge, arguing for further investment in psychosocial education.

Certification training

A standardised training evaluation form, with quantitative and qualitative items, including dimensions such as quality of training, knowledge of trainer and use of adult learning techniques, was used for each training session by the primary supervising trainer, a Syrian clinical psychologist, a second professional supervisor from the respective organisations, the peer co-trainer, and the participants. Feedback sessions were conducted after each FWT.

The training supervisors reported high knowledge absorption and ability to run trainings, as well as good consistency between self assessment (post training) and supervisor assessment. They cited clear methodological improvement, with practical knowledge rated at an average of 9/10 for the final trainings. The supervisors also reported significant improvement in psychosocial skills, but cited a continuing need for training to build greater practical aptitude. High absorption of psychiatric health curriculum by non-psychiatrists was also observed.

Attendance

Attendance rates for the first modules was 100%, and for the last ones 87.5%. Only four trainers out of 44 dropped out of the course; far fewer than expected. All dropouts occurred after Module 1, rather than slowly and throughout, indicating

strong programme adherence and commitment.

Master trainers' perceptions

Each module was rated by the master trainers on certain indicators, using a scale of 1–4; with 1 being '*Disagree*', 2 being '*Tend to disagree*', 3 '*Tend to agree*' and 4 being '*Agree*'. Quantitative and qualitative items captured the dimensions of training process, quality and satisfaction. Average ratings per indicator ranged from 2.84 to 3.65. Mean ranged from 3.1 for module 4, to 3.26 for Module 5.

The master trainers used an anonymous standardised training evaluation form after Module 6, with quantitative and qualitative items, similar to the form used for the certification trainings, and gave an overall average rating for principle trainers of 8.5/10.

The results of an overall quantitative and qualitative self-evaluation of knowledge and competencies at the end of Module 6 were measured with a scale from 1–10 (with 1 being '*very little*' and 10 being '*very much*'). Notable is that the highest self-perceived knowledge is in mental health and training methodology, the lowest it is in school counselling, indicating future training needs.

During a guided focus group discussion it was stated that the most important training experiences for the trainees were the handbook (a knowledge based resource), teamwork (multi-professional interaction) and generally how to run trainings and present information. This superbly followed the project's goals for their experience.

All of the master trainers graduated with success. The trainers, the Ministry of Health and the UN Resident Coordinator, certified the training.

Monitoring and external evaluation

Although the general frame was prepared through the needs and capacity assessments, consultations between trainers and the board chair, after every module, allowed fine-tuning of training content and methodology.

Additionally, in concordance with the larger PSS MH Programme administered by UNHCR, the Capacity Building Project underwent a midterm, mixed method, internal/external process of outcome/impact evaluation by a multi-professional team from the University of Uppsala, Sweden. The evaluation included four expert field visits in March, May, July and November 2010, a case study assessment and interviews with participants and trainers. The resulting recommendations have, for the most part, been fulfilled. A separate article is planned on the evaluation approach, process and results, but some notable points are worth mentioning here.

Structurally, the interagency nature of the Capacity Building Project, in conjunction with the initiation of the National Advisory Board, meant that there were numerous individuals active in the project, and that it was at times difficult to communicate clearly with all parties involved. The merger of the Interagency Working Group with the National Advisory Board, streamlining meeting attendants, resulted in more direct and effective communication.

Although it has been contested in the literature, the external evaluators found that this programme demonstrates the effectiveness of a cascade approach (Figure 3). The key to the success of this method is that modelling occurred on all levels of project implementation; most importantly the multi-professional approach, which was modelled at the Project Board level, just as much as in the trainings by the main trainers and master trainers.

Discussion

Successes

The collaboration among institutions and the multi-professional approach, characterised by the Capacity Building Project, defines a unique methodology for the PSS MH sector in Syria. Mental health care had been strongly medicalised prior to the implementation of this project, and now there is a greater understanding and integration of psychosocial concepts and practices, as reported through feedback from both master trainers and stakeholders. In response to the project, the first multi-professional PSS MH training and care unit has been planned within a government hospital. According to a follow-up assessment, both the MoH and MoE have integrated PSS MH capacity building in their annual work plans. Ninety percent of all master trainers confirmed that they had planned FWT sessions for 2011.

The handbook, the training package and the frontline worker field curricula, have laid the groundwork for incorporation of the developed curricula into regional institutions. Eventually, they will serve as a basis for further training and capacity building, with an opportunity for additional application in a variety of contexts across the mental health spectrum, regionally, and beyond. A national university expressed interest in incorporating the training into their postgraduate curricula, using the pool of master trainers as lecturers for planned cross-sectional PSS MH courses at the medical school and psychology department. The strong partnership between project board members allows for a clear coordination of leadership roles; bringing together high level stakeholders (such as the Ministries of Health and Education as well as Universities and the Syrian Arab Red Crescent) to provide an inclusive forum for

technical assistance, advocacy for international standards in PSS MH, and an opening for future policy dialogue. A High Level Round Table (comprised of the aforementioned stakeholders in addition to the Syrian Women Union and the Ministry of Higher Education), hosted by the Project Board, under the leadership of the Syrian Ministry of Health and UNHCR in November 2010, set the foundation for a formalised National MH PSS Council. This Council is modelled after the multi-professional Project Board, and integrates resources from the Ministries involved, in order to maximise expertise and access. The institution of this national body also has laid the groundwork for informed future policy decisions in the mental health sector.

Five of the master trainers are Iraqi, two of whom are Iraqi psychosocial outreach volunteers with the UNHCR Outreach Programme. Inclusion of outreach volunteers, and their invaluable perspective, in capacity building trainings is imperative. This inclusion empowers these vital actors, and facilitates positive identity reconstruction, not only for the trainers themselves, but also for the refugee and host communities. Importantly, it also allows national bodies to view refugee community involvement as an asset; by giving community members enhanced skills and agency.

Challenges and dilemmas

The agencies involved have different planning periods, and financial and budgetary regulations, requiring flexibility and creativity. Most funding is annual, and the lack of pooled funding hampered planning and a greater consistency of services. Therefore, a structure that would allow inter-agency projects to apply for communal grants, or allocate portions of funding to a collective pool, would be useful. Frequent

staff turnover, dependency on personal leadership, differing incentive policies across agencies and the bilingual nature of the project also created their own challenges. Consequently, a structure that facilitates the designation of staff to interagency projects, formalises information sharing and institutionalises commitments, as well as rotating leadership, would help to ensure continuity and equal participation of all agencies. Additionally, a structure that facilitates the deployment of staff to national stakeholders, in order to build internal capacity and national ownership, as well as leadership, is essential. Interagency politics and competition slowed the pace of progress, and impacted negatively on the team's enthusiasm. However, commitment to the project's potential overcame these challenges successfully.

Lessons learnt

Prior to the initiation of the PSS MH Programme and the Capacity Building Project, a thorough situation analysis was important in order to ensure an understanding of the system, and the local context (cultural, political and institutional). This allowed programme implementers to capitalise on the strengths of the system, supported by the development of strategic relationships.

The master trainers indicated clearly that continued supervision, assessment and follow-up workshops are crucial to monitor quality, support and to adjust the process accordingly. This corresponds to the main criticisms of the cascade approach, i.e., quality decreasing with moving down the cascade, and isolated trainings with limited supervision. Although aware of these challenges, the context necessitated this approach. The project design, however, addressed the challenges successfully by:

- Nominating master trainers through involved agencies, according to set criteria
- Mobilising and acknowledging existing resources across specialities
- Development, adjustment and provision of unified training material (this was found to be crucial to ensure a systemic approach to the training process, particularly as it cascades down)
- Using the first master training series as an opportunity to adjust the handbook material
- Extending the master training over a year with a maximum of one intensive module per month, allowing for knowledge absorption, reflection and practical application
- Utilising adult learning and participatory training methodology, as well as a practical focus in accordance with the *IASC guidelines*
- Responsible focal points per organisation (Figure 3)
- Piloting FWTs with training supervision and continued monitoring during the training cycle
- Continued trainee evaluation and intensive feedback provided, following FWTs
- Strengthening of independent coordination and peer exchange among participants beyond the training
- Organising follow-up workshops

One positive outcome of the cascade approach is that the FWTs are conducted by specialists, allowing for an exchange of perspectives and efficient referral system determination, thereby bridging hierarchies and easing burden sharing.

Interagency cooperation and the modelling of multi-professional teamwork were very valuable in creating attitude change over the course of this project. In addition, an interagency working group needs

committed leadership by one organisation, as well as a clear structure and identified roles and responsibilities for all actors involved, aligned with their respective mandates. Constructing commitments and institutionalising them was also helpful. At the same time, participatory engagement with all stakeholders from the beginning, and involvement of decision makers, as well as with experts from the different institutions, was crucial.

The development of a firm and early strategic plan that is logically linked to existing services is vital to keep stakeholders involved.

In order to ensure sustainability, project transition to complete national ownership is necessary. Therefore, allocating the time to carefully prepare this transition, and to develop an appropriate and well-articulated exit strategy that ensures continuity (including long-term vision and acceptance), is essential. Government participation from the onset laid a solid foundation. For this purpose, documentation throughout the life of the project is also very important; initiating the creation of institutional memory that outlasts staff turn over.

A design for programme evaluation should be integrated from the outset of the project, and continuous evaluation, throughout each stage of operation, as well as of the outcome/impact, is vital to maintain quality. For these reasons, a combination of external/internal evaluators was found to be highly effective.

Conclusion

As a result of the Interagency Capacity Building Project and national level, multi-professional coordination, the formal support systems have already demonstrated improvement of the skills and knowledge levels of the master trainers and frontline

workers. The development of unified materials that can be utilised beyond Syria, improvement of the system level, and the national coordination mechanism, also indicate project efficacy. Improved access and service delivery across Syria will eventually lead to the enhanced psychosocial wellbeing of the targeted population(s). The coordination network ensures improved response, monitoring of progress and integration of psychosocial support and mental health into existing systems of care.

The external evaluators selected the Syrian National Capacity Building Project as a best practice example for the mental health and psychosocial support sector. It is notable that many best practice examples are developed in emergency contexts, as these situations often facilitate the recognition of service gaps, and provide the opportunity to invest financial and human resources in a concerted manner. However, what is as essential, as it is challenging, is not to simply stop once the emergency has eased and access to funding becomes more difficult. Most often, in these cases, the services provided simply disappear, without the effective development of national programmes. The goal of this project and of all the team members was to invest instead in the integration of services into the Syrian system, enhancing national ownership and ensuring sustainability and a smooth transition.

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¹ For a definition of resettlement please see the UNHCR Resettlement Handbook at: <http://www.unhcr.org/pages/4a2ccb76.html>.

² For a definition of a complex emergency please see the Complex Emergency Database at: <http://www.cedat.be/glossary>.

³ For a definition of a protracted refugee situation please see: UNHCR. *Protracted refugee situations* (EC/54/SC/CRP.14), June 2004.

⁴ UNHCR, UNICEF, the United Nation's Population Fund (UNFPA), the World Health Organization (WHO), the International Medical Corps (IMC), the German *Gesellschaft für Technische Zusammenarbeit* (GTZ) with support of the European Commission.

⁵ A separate article is planned on the master training methodology.

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Announcement

Join the Mental Health and Psychosocial Support Network

Approaches to providing mental health and psychosocial support (MHPSS) are evolving rapidly, and examples of good practice are fast emerging from the field. However, those working in MHPSS are dispersed across the world, separated by language, culture, professional roles – with varying access to information and communication technologies. The MHPSS Network is set up to close the gap in the sharing of information, resources and expertise.

What does mhpss.net have?

MHPSS Network is built around an interactive website: a place to meet colleagues, create discussion groups to seek advice or exchange views, share documents through a digital library and post events, training courses and vacancies.

Who can join mhpss.net?

Anyone around the world with an interest in mental health and psychosocial support can join the network. This includes people from affected communities, as well as those working in all levels of humanitarian or development aid, government, policy, training, academia and media.

Access the MHPSS Network at www.mhpss.net

The integration of mental health into primary health care in Lebanon

Zeinab Hijazi, Inka Weissbecker & Rabih Chammay

In Lebanon, the International Medical Corps is working to address the multiple needs of Iraqi refugees, as well as the long term needs of the vulnerable host population, by integrating mental health services into primary health care (PHC). Over the past two years, 152 PHC providers (doctors, nurses and social workers) were trained in the identification, management and referral of people with mental health problems. The Ministry of Health has certified the completion of a training that includes: 12 theoretical training days, and a minimum of three on-the-job, supervised clinical sessions. Two formative evaluations were conducted to guide training implementation. Trainees completed pre/post tests, and clinical skills were evaluated during the on-the-job supervision sessions. Trainees showed an average of 12–25% improvement in knowledge, and 85% doctors and 91% nurses met minimum competency standards. Results from the evaluation were used to address challenges, including: strengthening referral mechanisms; promoting organisational change through clinic management; tailoring training for different groups of professionals; utilising a team approach to care, providing refresher training on topics such as medication management and planning longer term follow-up. The project provides important input towards integrating mental health into primary health, on the national policy level.

Keywords: integration, iraqi refugees, lebanon, mental health, primary health care

Introduction

Mental illness continues to be one of the most neglected and under-funded health

problems, causing significant disease burden and vulnerability. Approximately 75% of individuals with mental health problems in many low income countries have no access to appropriate services (World Health Organization, 2008a). Integrating mental health into general health care is one of the most viable ways of closing the treatment gap for untreated mental illnesses (World Health Organization, 2008a; Lancet Global Mental Health Group, 2007). This integration can be achieved by training general healthcare workers in the identification, management (pharmacological and non-pharmacological), and appropriate referral of mental health cases, as outlined by recently released WHO Mental Health Gap Action Programme (mhGAP) guidelines (World Health Organization, 2010b). Such integrated services are more sustainable, less stigmatising and more accessible through reaching larger segments of the population (Inter-Agency Standing Committee, 2007). Integration is most successful when mental health is incorporated in health policy and legislative frameworks, accompanied by adequate resources (World Health Organization, 2008b). Efforts to integrate mental health into general healthcare are increasingly documented in several low resource countries (World Health Organization, 2010b). The International Medical Corps (IMC) has been conducting programmes supporting mental health integration into general health care in Sri Lanka, Sierra Leone, Chad, Iraq, Syria,

Haiti, and Jordan. This article describes the situation in Lebanon, which illustrates the challenges and opportunities in this line of work.

The Lebanon context

Background

Lebanon is an upper middle income country with a population of approximately 4,350,000. This includes 500,000 refugees from different nationalities, of which 47,280 are from Iraq. Most others (around 400,000) are Palestinians served by UNRWA, the United Nations Relief and Works Agency for Palestine Refugees (UNHCR, 2010, World Health Organization, 2010a). IMC started to work in Lebanon after the war in 2006 that involved the Hezbollah paramilitary forces and the Israeli military. The conflict led to the deaths of over 1,400 people, most of whom were Lebanese, and displaced a further 1,275,000 people. The political and security situation in Lebanon and the surrounding region remains unstable. There is no adequate legal framework that addresses the short or long term needs of refugees, who often work illegally, suffer exploitation, and are subject to detention and deportation (UNHCR, 2010). Survival remains a daily struggle given deteriorating health, plummeting income levels, poor, over crowded living conditions, and uncertain futures (Le Roch et al., 2010).

Mental health

Prevalence of Mental Health Problems

According to a 2006 national epidemiological survey in Lebanon, 17% of respondents met criteria for at least one mental disorder in the last 12 months (Karam et al., 2006). In another study, the lifetime rate of major depression in Beirut was reported to be 19%, and higher proportions of mental disorders were found in respondents exposed

to multiple war-related distressing events (Weissman, Bland, & Canino, 1996). High levels of psychological distress were also reported among 50% of Iraqi refugees, and 34% of these had experienced extremely stressful events such as: witnessing the assassination of relatives and friends; kidnapping; torture; and rape (International Organization for Migration, 2008). Women were found to be taking up new responsibilities, while men saw their role and mandate being eroded. Terre des hommes-Lausanne (TdH-L), who were providing psychosocial support and counselling to Iraqi refugees in Lebanon, found that of the 83 clients who sought psychosocial services, the majority suffered from emotional disorders (92.7%) followed by behavioural disorders (55.4%) and sleeping disorders (48.2%) (La Roch et al., 2010).

Mental health services

Lebanon primarily depends on the private sector for the provision of mental health services, which are free of charge for eligible low-income patients through the Ministry of Health (MOH). Specialised mental health services are available at three private mental hospitals, and five psychiatric units within general hospitals, which are located centrally around the capital, Beirut. There is a lack of community based mental health services, and services are not available in every catchment area (WHO, 2010b). Lebanon has relatively few mental health specialists, with an average of two psychiatrists per 100,000 of the population (WHO 2010b). The budget for mental health constitutes 5% of the general health budget, which is mainly allocated for long stay inpatient costs in mental hospitals. Whereas outpatient, community based services are the responsibility of the private sector, with no budget except those that provide selected

psychotropic medicines for free. Mental health care provided through primary health care (PHC) is typically restricted to prescription of medication through the doctor (and, in our opinion, seldom properly). Few clinics have social workers that are trained in mental health. Lebanon does not have a current mental health policy or plan, which has been cited as one of the main barriers to improving mental health services.

Individuals are often reluctant to visit mental health services due to fear of stigma. Data from the country suggests that only 10% of those with mental disorders seek care, mainly from general physicians at clinics, or polyclinics that are operated by private doctors, or charities, but not by mental health professionals (Karam et al., 2006; World Health Organization, 2010a). The data further suggests that of those who do receive services, 85% are treated in the general medical sector and the mental health care system, and the rest by religious or spiritual healers. One study found that Iraqi refugees are unlikely to seek out mental health services due to: stigmatisation of such services in their country; limited accessibility; and lack of community outreach (IOM, 2008). The expression of unspecific somatic complaints, instead of psychological problems, is common among both the host population and the refugees (IOM, 2008).

Integration of mental health into primary health care in Lebanon

Context

Since the ceasefire in the war between Israel and the Lebanese Hezbollah went into effect in August 2006, IMC has been working with local partners and governments to provide basic primary health care services, secondary and tertiary healthcare, and health

education. Funding has focused on addressing multiple and complex needs of refugees and the host population in Jordan and Syria, which included mental health services, since 2007. Training PHC staff to integrate basic mental health care into their clinical and public health practice became a way of meeting refugee and host population needs, as detailed in the following steps.

Project coordination and collaboration

Government

At the end of the 2006 war, IMC recruited psychiatrists and psychologists as trainers from the Lebanese Institute for Development Research Advocacy and Applied Care (IDRAAC), and trained national primary health care staff of a local health NGO (AMEL Association). In 2007, ten PHC clinics across Lebanon were targeted in a pilot to inform discussions with the government on the possibilities of integrating mental health into PHC, at a national level. In 2008, IMC built on the piloted training, and held discussions with the MOH General Director, sharing the training programme framework and work plan. The MOH was supportive of the NGOs work as a result of past successful health programming, and offered their support in training MOH PHC staff in Lebanon's eight provinces¹. The MOH has been subsequently involved in approving the training material, and has certified the training. IMC has continued to actively involve the MOH in an effort to take the first steps in informing a mental health plan in Lebanon.

Professional associations

In 2008, IMC, Lebanese psychiatrists and service providers formed an advisory board that collaborated on developing the mental health training programme. The board consisted of an MOH psychiatrist, the head of the Lebanese Psychiatric Society, a

psychiatrist consultant, and the IMC programme manager and two psychologists. The board's role ended in August 2009.

The Head of the Lebanese Psychiatric Society approved the training manual in October 2009, who also submitted the material to the Lebanese Order of Physicians (LOP). In February 2011, the LOP approved the provision of Continuing Medical Education (CME) credit to trainees (doctors registered with the LOP) who completed both the theoretical, and the on-the-job, training components. This was a lengthy process and was only completed at the onset of the third cycle of training. Trainees from the previous two cycles received training certificates, accredited and signed, by the Minister of Health.

Mental health PHC training design

Timeline The PHC training took place from February 2007 to August 2010, and included three training cycles, with twelve theoretical training days per cycle over three months (one day per week), and two formative evaluations (see Table 1).

Selection of PHC clinics

Cycle I trainees were selected by the AMEL Association. Cycle II and III trainees were recruited from seven NGO-supported general health clinics, and 18 clinics supported by MOH, the Ministry of Social Affairs (MOSA) or local NGOs. The MOH agreed with the selection of the clinics. These were located in five of the eight provinces with both a large proportion of Iraqi refugees, and a vulnerable host population.

Selection of PHC staff

General practitioners (GP) were selected through a formal recruitment process, approved by the government, using the following criteria; being a certified GP, having at least two years experience at the PHC

level, and being willing to attend the required days of training. Doctors with specialties (e.g. gynaecology), who had also practiced as GPs, were also eligible. PHC doctors, who had participated in the training, nominated mid-level staff from their respective clinics for inclusion.

PHC training materials and content

The *Mental Health Training Manual* was drafted by Lebanese psychologists and reviewed by international mental health specialists from IMC, and the Lebanese Psychiatric Society (LPS). The manual was based on previous IMC material, *IASC Guidelines on Mental Health and Psychosocial Support in Emergencies* and *'Where There is No Psychiatrist'* by Vikram Patel (2003). Topics were selected based on the first formative evaluation, assessments of the most prevalent disorders seen at the PHC level (as indicated by trainees as part of their application form, and discussions with heads of clinics and the MOH) and periodic revisions throughout Cycle II. Trainees indicated that they were most interested in: depression; anxiety; medically unexplained complaints; and sleep problems. The topics included in the final manual are outlined in Table 2. Medication management was addressed as part of each relevant mental disorder and covered: prescriptions, dosages, and overall management for GPs; and basic pharmacology, duration of treatment, side effects, medication compliance and psycho education for mid-level staff.

More specialised topics were included for specific groups of trainees. Gynaecologists received training on: detecting domestic abuse; providing support and linking survivors of violence to services; post partum depression; and post partum psychosis. The training for paediatricians emphasised: behavioural disorders in children; maternal

Table 1. PHC Mental Health Training Overview

	February 2007- august 2007	September 2008- august 2009	September 2009- august 2010	
	Cycle I	Cycle II	Cycle III	Total
Total # of trained PHC workers	17	75	60	152
GPs	6	43	20	69
Paediatricians	2	18	7	27
Gynaecologists	4	6	3	13
Nurses	5	4	13	22
Social workers	0	4	15	19
Admin/head of clinic	0	0	2	2
Trainees completing 12 training days	NA*	100%	100%	NA
Trainees completing at least three on-the-job training supervised clinical sessions	90%	38 % mid level staff 50% doctors	100%	NA
Number of trainees completing pre/post test	NA**	74	56	130
Average pre test %	NA	63%	48%	NA
Average post test %	NA	75%	74%	NA
% Improvement	NA	12%	25%	NA

No formative assessment

End of cycle II
1st formative assessment

End of cycle III
2nd formative assessment

* Training in cycle I included four training days only

** Results not available

*Training in Cycle I included four training days only. ** Results not available.

depression; monitoring a child (height/growth) taking methylphenidate for attention deficit hyperactivity disorder (ADHD); recognising signs of child abuse and neglect; and paying attention to school performance as a signal for exploration of other problems. The training was consistent with an adult learning perspective (Bryan et al., 2009), where trainees (and managers) were engaged in discussing the rationale of learning about mental health, and the challenges to be addressed. Trainings were tailored to trainees from different backgrounds, and encouraged active involvement in the

learning process and to provide feedback. Educators not only served as the distributors of content, but also were involved as facilitators of learning, and assessors of competency. The theoretical training consisted of four training days in Cycle I, and 12 training days in Cycles II and III. The increase in training days (from 4 to 12) was the result of recommendations from the mental health team and the advisory board. The on-the-job (OTJ) supervision component consisted of at least three days, and started after 6–7 days of theoretical training. Each trainee was assigned a psychiatrist for technical

Table 2 PHC mental health training content

Day 1	Day 7
• Pre test	• Child and adolescent mental health
Introduction to mental health	· Mental retardation and learning difficulties
· Concept of mental health and disorder	· Child abuse
· Communication skills and effective interaction	· Conduct disorder
· Misconceptions of the mentally ill	· Enuresis
• Biology and the mind	· Adolescence
· Brain vs. mind	• Elderly mental health
· Motivational, emotional, and cognitive processes	· Dementia
	· Elderly abuse
Day 2	Day 8
• Assessment of mental disorders	• Addiction and substance abuse
· Types, symptoms, and etiology of mental disorders	· Process of addiction
• Psychiatric interview	· Different classes of drugs
· Mental status examination	· Management and treatment
· Writing case summaries	• Midterm
Day 3	Day 9
• Mood disorders	• Psychiatric emergencies
· Depressive disorders	· Epilepsy/seizures
· Bipolar disorder	· Delusions and hallucinations
· Etiology of mood disorders	· Suicide
· Differential diagnosis	· Case management and referrals
· Managing mood disorders	
· Treatment and psychopharmacology	
Day 4	Day 10
• Anxiety disorders	• Trauma
· Characteristics and etiology of the different types of anxiety disorders	· Loss and grief
· Managing anxiety disorders	
· Treatment and psychopharmacology	· Domestic violence
Day 5	Day 11
• Somatoform disorders	• Treatment of mental disorders
· Different types of somatoform disorders	· Psychopharmacology
· Etiology of somatoform disorders	· Medication management/case management
· Management and treatment	· Counseling therapy
• Sleep disorders	• Referral system
• Sexual dysfunction disorders	
Day 6	Day 12
• Severe mental disorders	• Closing subjects
· Psychosis	• Relaxation techniques for managing stress
· Schizophrenia	• Q&A discussions
· Brief acute psychosis	• Post Test
• Eating disorders	
· Anorexia nervosa	
· Bulimia nervosa	

consultations, who also observed while they saw patients.

Refresher training

Refresher training consisted of at least two theoretical training days, and at least one follow up OTJ training day for staff, from all cycles. The training was based on previous formative evaluations on training gaps and was tailored to staff specialisations: GPs reviewed how to use proper prescribing habits; paediatricians received in-depth sessions on child and adolescent mental health; gynaecologists received training on identifying, managing, and referring cases of abuse; while gastrointestinal doctors practiced identification and management of psychosomatic complaints. Mid-level staff was trained on psychosocial interventions including family supports. The refresher training was consistent with WHO Mental Health Gap Action Programme (mhGAP) guidelines.

Mental health PHC training assessments

First formative evaluation

The first evaluation, conducted by an external evaluator (from the American University of Beirut), took place after Cycle II, with the objective of standardising the training materials. Three ($n = 6$, $n = 5$ and $n = 7$) two-hour focus group discussions (FGD), including GPs and mid-level staff, were conducted by a facilitator and one note-taker with participants from Cycles I and II. Questions focused on the logistical aspects of the training, content, presentations and subjects, quality of trainers, and quality and feedback from the OTJ sessions. All participants were contacted by psychosocial field officers and asked whether they would be interested in taking part in the FGD on specific dates. The facilitator conducted in-depth interviews with the three main

trainers (Technical Mental Health Advisor, Head of the Lebanese Psychiatric Society and MOH psychiatrist) to obtain feedback on the training.

Second formative evaluation

The second evaluation was carried out at the end of training Cycle III to obtain feedback on the training, and to inform the design of refresher training. Five two-hour FGDs were held by one facilitator (trainer) and one note-taker with participants from Cycles II and III (GPs $n = 7$ and $n = 8$; mid-level staff, $n = 6$; Paediatricians, $n = 5$; Gynaecologists, $n = 2$). Questions focused on general impressions of the training; appropriateness of topics; experience of trainers; ability to identify, diagnose and refer cases of mental illness; appropriateness of the OTJ trainings; and interest in refresher training.

Knowledge and competency measures

Mental health knowledge was assessed with a 50-item test developed by the project, which consisted of brief case studies, and multiple choice questions on diagnosis, management, and referral. The test was administered before, mid-term (22 items), and after the theoretical training. The goal of the mid-term was to determine knowledge gaps to be addressed while training was ongoing.

Clinical performance was measured by the psychiatric OTJ supervisor, using a Competency Checklist adapted from the 'mini-CEX for specialist training in psychiatry, Royal College of Psychiatrists' (see Boxes 1 and 2 for a sample of the checklist administered to GPs. The checklist assesses the ability of the trainee to: establish rapport; demonstrate active listening; basic attending; the ability to communicate competence; make appropriate referrals; and write case reports. Each skill was graded using a 5-point scale ranging from 1 (demonstration of the task or usage of

Box 1: Ample questions from mental health knowledge pre/post tests

1. Samira is 14 years old, and for more than a week she has had decreased appetite, refused to go to school or partake in activities she once considered fun and enjoyable, and says she is tired all the time and mostly sighs and sulks. She is normally, by nature, very optimistic but has been heard talking about death and wondering what the purpose of life is all about. She avoids social events where she has to interact with friends or people. Her mother became worried when she received a call from Samira's principle telling her that Samira is on the verge of failing three of her courses. When talking to her about her grades, she said to her mother, 'who cares? Just leave me alone. We're all going to die in the end anyway.'

1.1. Samira's pattern of behavior indicates which of the following disorders?

- a) Panic disorder
- b) School refusal
- c) Social phobia
- d) Major depression disorder
- e) Separation anxiety disorder

the skill was not completed as expected) to 5 (demonstration of task or usage of skill was excellent). Minimum competency standards of a 4-point average ('Good') were agreed by IMC's Mental Health Technical Advisor and the psychiatrist supervisors. The checklist was administered.

Mental health PHC training results

First formative evaluation

Qualitative results indicated that the training benefited the trainees by allowing them to: network and share experiences with colleagues; increased their awareness of mental health issues within their work and social

environment; and improve their ability to listen to patients and identify mental health problems. Main recommendations included: separate groups for physicians and non-physicians; provide more time for case discussions and role-play; address rational use of medications in each topic session (including when to start, monitor and discontinue, medication); focus more on family support for mid-level staff; conduct refresher trainings on some topics (e.g. depression); recruit physicians and mid-level staff from the same clinics in order to facilitate joint and coordinated service provision; and start OTJ training during theoretical training.

Second formative evaluation

Participants reported that the training offered them an opportunity to network and engage in discussions with peers about using newly acquired skills, increased their communication and listening skills, heightened their tolerance for patients presenting with vague and/or persistent complaints, enhanced awareness of mental illness symptoms, and improved their ability to recognise somatisation and differentiate between organic and mental health problems. Quotes from trainees included: *'after the training, the way I dealt with patients changed, I started to listen to them more and I want to know about their history and what got them here'; 'w, I can diagnose depression and assess matters. I pay attention to mental health symptoms, and some have come back to see me.'* Trainees also seemed to undergo a change in attitude towards mental illness, stating for example: *'I used to think that a fainting woman wanted only to have the attention of the doctor and that she was faking it, now I know that she is not'; 'after this training, I realised that I was depressed, I went and saw a psychiatrist'; and 'I understand better what my teenage son is going through, we talk more.'*

Trainees reported being better able to identify common mental disorders, such as

Box 2: Mental health on-the-job training. Competency checklist and goal setting form

Doctor's name:

Place:

Supervisor's name:

Please use this scale to assess the practicum student's skills:

5 - Demonstration of this task *or* usage of this skill was: EXCEPTIONAL

4 - Demonstration of this task *or* usage of this skill was: GOOD

3 - Demonstration of this task *or* usage of this skill was: FAIR

2 - Demonstration of this task *or* usage of this skill was: POOR

1 - Demonstration of this task/task *or* usage of this skill was: NOT COMPLETED as expected

Assessment / intake skills	Skill level	Comments
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Taking appropriate history of patient's presenting complaints

Taking appropriate psychiatric history

Taking appropriate medical history

Taking family history

Taking occupational history

Asking questions about patient's daily functioning

Communication skills	Skill level	Comments
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Demonstration of core conditions of genuineness, unconditional positive regard, and empathy in the doctor-patient relationship

Demonstration of active listening, basic attending, and ability to communicate competence

Practice skills	yes	no	Comments
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Makes correct diagnosis

Takes appropriate decision re: medication & treatment

If prescribing, gives correct advice & information about the drug

Records data correctly

Provide clear instructions & explanations for patient about his/her problem

Includes psychosocial component in the treatment

Goal	Comments
------	----------

1

2

3

depression and anxiety, although they remained less confident diagnosing more severe disorders, such as schizophrenia and bipolar disorder. Trainees also expressed reluctance to prescribe medication, were unsure about how to manage medications and where to refer and how to follow up. Trainees stated, for example; *'we benefited from assessing and analysing cases, but when it came to our practice, it was harder. I don't have the courage to prescribe medication.'* Nurses and social workers requested training on prevention. Trainees requested more OTJ sessions, and regular follow-up for at least one year following the training (consultation visits once a month), and that trainers remain points of reference for technical questions. Additional topics requested included stress management, preventing burnout, and communicating with angry or violent patients.

Knowledge and clinical competency

Results of the *mental health knowledge* test among trainees who completed the training ($n=96$, Cycles II and III, see Table 1 for details) showed an average of 57% correct answers on the pre-test ($n=130$ Cycles II and III), 81% on the mid-term ($n=30$, PHC doctors from Cycle III only) and 74% on the final ($n=130$ Cycles II and III). This corresponds to an 18% improvement in knowledge. It seemed that participants in Cycle III had somewhat lower pre test scores than other cycles, which may also be because this group encompassed PHC workers less familiar with mental health care, in more deprived areas, with Iraqi refugees. Mid-term results had shown that trainees had a good understanding of differential diagnosis, but had difficulties in identifying the correct medications for common mental disorders. Subsequent revision

sessions addressed this gap, and knowledge was further increased on the post test.

Results regarding *clinical performance* indicated that doctor trainees achieved an average rating of 86% ($n=96$ Cycles II and III), while 85% met minimum competency standards, with 60% meeting high competency standards using the Competency Checklist. Among mid-level staff, 92% ($n=33$ Cycles II and III) met the minimum competency standards, with 38% (of the 92%) meeting high competency standards. Main difficulties reported by the supervisors included: patients not showing up; doctors not asking enough questions; pushing the trainer to intervene if mental health issues were communicated; over emphasising psychological components, while forgetting about the medical examination; short consultation time; no confidentiality or privacy; and leading questions asked by physicians.

Results of the knowledge pre/post test, and the OTJ training checklist, carried out at the end of Cycle III, indicated that while trainees' identification of mental disorders improved, they still had difficulty knowing when to refer patients, when to prescribe medications, and explaining the purpose behind the medication, and dosages, as well as managing follow-up cases and knowing when to discharge.

Discussion

Challenges and lessons learned

Between 2007 and 2010, IMC built on formative evaluations and lessons learned in designing a training programme of mental health integration that fit with existing resources, structures and systems, and proved to be a comprehensive and effective training. There are several challenges and lessons learned that emerged over the course of the project.

Prescribing habits

Formal evaluations and supervision reports from trainers suggested that a significant number of doctors continued to maintain their old prescribing habits, and showed resistance to prescribing antidepressants, while continuing to prescribe benzodiazepines. This problem was surprising, given that this topic was covered extensively during both the theoretical and OTJ training. In response, refresher training was focused on proper prescribing and medication management, and included case discussions from the GP's respective practices.

Team approach to care

Formative evaluations and experiences indicated that mental health at the PHC level needs to be provided through an all-inclusive trained team of medical professionals and social workers working together, with a need for long term follow up, support and supervision. This is particularly crucial in absence of a gatekeeper. Therefore, IMC developed an approach to tailor training to GPs, mid-level staff, social workers, and doctors from different specialties. Staff had also indicated a preference for separate groups (first formative evaluation) and this approach seemed to work well for meeting training needs and increasing comfort of staff to openly talk about challenges. The organization is also currently piloting the integration of case management teams attached to PHC clinics, by engaging three case management teams that include social workers, psychologists, and psychiatrists working with clinic staff, on managing patients in need of psychiatric, psychological and social support.

Ongoing supervision and support

A key finding from the formative evaluations was that trainees needed to be followed-up after the conclusion of training. Trainers

and trainees reported that they created informal networks to ask for technical input on cases seen at the PHC level. IMC also organised refresher trainings for one year following the initial training. In addition, there are plans to strengthen communication and consultation among trained PHC staff and mental health specialists by strengthening referral networks, and setting up two supervision units, made up of a psychiatrist, psychologist and social worker or psychiatric nurse. The supervision units will be stationed within ministry clinics or local organisations, that can sustain the units following NGO-support, in 2 out of 4 regions in Lebanon, where partner clinics are situated, and almost no secondary mental health services are available.

Referral networks

The integration of mental health into PHC is reliant on a coordinated network of community services, including specialised mental health services. However, appropriate referral systems between primary, and secondary services were often absent, and many trainees indicated difficulties in determining where to refer. In response, IMC strengthened referral networks and mapped free and accessible mental health services within the five geographical areas of partner clinics, and produced a referral booklet that was shared with the MOH, NGO PHCs, and other service providers.

Organisational integration

Training clinical staff was insufficient if the head of the clinic did not promote the organisational integration of mental health into PHC services. Such organisational changes included proper assessments, management and follow-up, spending more time with patients, or allocating sessions or even a day, for mental health cases. Heads of clinics

face significant challenges, including shortage of staff, inadequate working conditions, and limited budget and resources. PHC trainees expressed that they want to be supported in lobbying for mental health integration. As a response, IMC organised a one-day orientation session for heads of clinics, focusing on the importance of integrating mental health, to determine roles of trained PHC workers, and to discuss their own role in supporting integration.

Data tracking and reporting

PHC clinics in Lebanon do not routinely track mental health patient data, such as diagnosis, medications, intervention management and referral. IMC developed an outpatient record form, but this was not regularly used. Tracking and reporting on mental health data is one aspect of mental health PHC integration that requires institutional agreement, and organisational change and commitment. As a result, IMC is planning to work with PHC heads to advocate for, and support, integration of mental health at all levels, including reporting.

Limitations

This project has had several limitations. The data collected was mostly qualitative, and evaluations were formative. Modifying the training continuously, based on feedback, may have also resulted in trainees with different knowledge and skill levels. However, the refresher training has been designed to address specific knowledge gaps. Furthermore, ensuring that evaluations and feedback were built into the project design made it possible to develop a mental health training programme closely tailored to trainee needs in Lebanon.

The overall objective of this project was increasing access to mental health services

for vulnerable populations, including Iraqi refugees. It should be noted that we primarily analysed activities and results, rather than outcomes. This project also did not measure patient levels and organisational outcomes, which would have shown greater access to, and utilisation of, services. These included: changes in number of cases identified, managed, and referred at the PHC level; and the use of referral links and consultations (with trainers and providers of secondary mental health services). However, it should also be noted that this project had a longer term impact of leading to further funding of activities, opportunities for further evaluation, and impact on national policy. Furthermore, this article is describing a pilot process evaluation to guide programming, and IMC is currently planning to carry out a formal evaluation of its programme to evaluate patient levels and organisational outcomes.

Contributions to national policy and practice

From the start of the project, IMC has worked closely with governmental actors and other key stakeholders. In June 2010, a memorandum was drafted, with the collaboration of the LOP, with plans to take the first steps towards integrating mental health into the PHC on a national level. The memorandum delineates the responsibilities of LOP, such as: 1) provision of training space; 2) participation in reviewing and approving training material (in collaboration with IMC and the Lebanese Psychiatric Society), for the provision of CME credits; 3) facilitating provision of CME credits to trained PHC doctors; and 4) advocating for the establishment of a National Mental Health Policy to integrate mental health into the PHC. WHO and MOH have identified a consultant to carry out a national situation analysis on mental health, and produce a

strategy with a three year national mental health plan. The technical committee includes the local IMC mental health coordinator. Objectives of this strategy include establishing catchment areas for mental health services, GPs as gatekeepers, and a referral system between PHCs and secondary care. IMC has also been engaged in discussions with MOSA to review the national emergency plan currently pending approval at the ministry, and to include trained PHC workers within its first response framework. In this case, therefore, trained PHC staff would be able to provide first line mental healthcare during an emergency.

This project serves as one example of designing a mental health PHC integration curriculum and training, involving formative research, programme modifications, and close collaboration with the government and key stakeholders. Future activities will focus on providing continued refresher training, strengthening referral systems, and supporting integration of mental health at the PHC organisational level, with the goal of contributing to, and informing, national mental health practice and policy.

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¹ Akkar, Nabatiyeh, Baalbek, Beirut, Beqaa, Mount Lebanon, North Lebanon, South Lebanon.

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Strengthening mental health care in the health system in the occupied Palestinian territory

Susana de Val D'Espaux, Bassam Madi, Jamil Nasif, Mohamad Arabasi, Sa'eda -Raddad, Amal Madi, Noha Abu-Alrob & Alberto Fernández-Liria

The authors describe a programme in a rural area of the West Bank (occupied Palestinian territory) developed in 2005 by Médicos del Mundo Spain, in coordination with the World Health Organization and the Ministry of Health. The main features include: 1) working with the Palestinian Authority in order to reinforce the existing public health system, rather than developing a parallel one; 2) providing a building, and other long lasting material resources, to the Community Mental Health Centre and the public health system; 3) supporting the incorporation of human resources in mental health teams in the public system; and 4) providing capacity building for mental health and primary care teams, through intensive on the job training, and providing didactic material for mental health and primary care professionals. The integration of mental health care into primary health care structures in conflict settings provides the opportunity of addressing severe and common disorders in their current situation.

Keywords: community mental health services, integration of mental health into primary care, occupied palestinian territory, political violence, public health

Context

Approximately 3.8 million people living in the occupied Palestinian territory (oPt, West Bank (WB), Gaza, and East Jerusalem) exist in chronic conflict, living under Israeli

military occupation since 1967. Gaza is next to the Mediterranean Sea, with about 1.5 million people living within 360 sq km, divided into five governorates. The West Bank comprises an area of 5,800 sq km, with 11 governorates and 2.3 million people. In 2002, Israel started the construction of a separation wall between the West Bank and Jerusalem. Around 225,000 Palestinians live in East Jerusalem (Palestinian Central Bureau of Statistics (PCBS), 2007). Fifteen percent of Palestinians live in 27 refugee camps, where poverty and unemployment rates are high (United Nations Relief and Works Agency, 2011). These camps were supposed to provide temporary shelter for the displaced from the Arab/Israeli war in 1948, however, during the occupation in 1967, the numbers grew. Around 500,000 Israelis live in settlements and outposts in the West Bank, and Jerusalem (Office for the Coordination of Humanitarian Affairs (OCHA), 2011). This is illegal under international law, and the camps are often located in strategic areas with water resources and agricultural land (Palestinian monitor factsheet, 2010). Since 2006, Internal Palestinian political division led to one party ruling Gaza, and another party the West Bank. Israel controls the airspace, territorial waters, natural resources, movement of people and macro-economic instruments

that enable economic autonomy (Mushasha & Dear, 2010). In 2007, in Gaza, Israel began a strong blockade that left it isolated, reducing the supply of basic goods (such as food, money, fuel, glass, and medication) and restricting the movement of people, in and out of the area. In more than 60% of the West Bank territory, Israel retains control over security, planning and zoning. It is estimated there 22% of the population faces food insecurity in the West Bank (World Food Programme, 2010).

Mental health problems should be framed within an historic context covering the location where the person lives (Martín-Baró, 1990). The political, cultural and social dimensions should also be taken into account when assessing any psychological dysfunction caused by exposure to traumatic events (Blanco, Díaz & del Soto, 2006). Check points, construction of the wall, the siege of the Gaza Strip, fragmentation of territory, and the illegal annexation of east Jerusalem by Israel has all undermined the Palestinian social fabric, and has had negative consequences on the psychological wellbeing of the population. This ongoing structural violence, along with home demolition, settlements, military incursions, and the Palestinian political polarisation, has led to collective distress. Most Palestinians have experienced physical and psychological violence, and have had their human rights undermined; deprived of freedom of movement, existing under curfews, being shot or bombed. Giacaman et al. (2007) found that collective exposure to trauma and violence was a strong predictor of a depressive-like state. Social suffering affects mental and somatic health (Giacaman et al., 2010; Martín-Baró, 1990). Mental health cannot be understood using a pure medical perspective with only medical indicators. During conflicts, a framework that includes

a human rights perspective and an orientation to social justice is needed (Moran et al., 2011). Worldwide around 2–3% of the population have severe and disabling mental health disorders, which are expected to rise to 3–4% after severe trauma or loss (World Health Organization (WHO), 2005). Another important feature to consider is that 75% of the population in the occupied Palestinian territory is less than 30 years old, and only 3% is more than 65 years old. Therefore, it can be assumed that there will be a high presentation of mental illnesses that are typically highly prevalent among younger people, such a first episode psychosis (WHO, 2006). In the oPt, children and adolescents have lived all of their lives in conflict, and are chronically exposed to traumatic events and violence that affect their mental health status. The severity of the traumatic situation, the coping strategies of the child and the ways mothers respond to life threatening situations were found to be the main determinants for the mental health status of the children (Qouta, Punamaki & El-Sarraj, 2003).

Exploratory mission of Médicos del Mundo

The Spanish section of the nongovernmental organisation (NGO) Médicos del Mundo (MdM) launched its first mental health programmes during the Bosnian war in 1994 (Díaz del Peral et al., 2002; Fernández-Liria, & González-Aguado, 1995). From this first mental health project the main components have remained the same: a community oriented public health approach, with strong psychosocial elements, to target people with severe mental health disorders and their families, to engage health workers, and to strengthen the public health system to work towards sustainability.

Two exploratory missions to the oPt, in 2004 and 2005, found inequitable distribution of health facilities between and within the West Bank and Gaza Strip (Mataria et al., 2009), (Table 1). A Steering Committee for Mental Health, consisting of the Ministry of Health

(MoH), NGOs, United Nations agencies and international donors, developed a plan for the organisation of mental health care services in the occupied Palestinian territory (Strategy Operational Plan (SOP), 2004.)

Table 1. Mental health system in the occupied Palestinian territories in 2004 and 2011

• Policy, plans and programmes:

2004 – A SOP was officially adopted in 2004 along with a five year implementation plan.

2011 – The SOP 2011–2013 is approved.

• Legislation:

2004 – There is no specific mental health legislation, but the Palestinian National Health Plan of 1994 considered mental health as a priority area.

2011 – Creation of a National Technical Committee to develop a code of ethics and to finalise a law on mental health started in 2001.

• Organisation:

2004 – Two departments: CMH that falls under the authority of PHC, and the Psychiatric hospital under the authority of Hospital administration.

2011 – In the WB, a Mental Health Unit that falls under the authority of PHC. In Gaza a Mental Health Directorate independent of PHC authority, and at the same level.

• Outpatient clinics and CMHC:

2004 – 42 public and private. Nine in the WB and four in Gaza are from MoH, 37% of users are estimated to be female and 15% to be children and adolescents.

2011 – In Gaza, six CMHC and one for children. In the WB there are six CMHC and one for children.

• Mental hospitals:

2004 – Two public, one in Gaza and one in the WB.

2011 – Two public, one in Gaza and one in the WB that are being improved in terms of human rights and recovery promotion.

• PHCC from MoH:

2004 – 44 in Gaza and 329 in the WB.

2011 – 110 in Gaza and 370 in the WB.

• Advocacy:

2004 – A nucleus of family associations.

2011 – Family associations has been established and a representative is involved in trainings, in the groups and committed to develop the mental health system.

• Human resources:

2004 – Working in public MH, NGO, private sector in the WB and Gaza:

32 psychiatrists, 12 medical doctors, 125 nurses, 36 psychologists, 40 social workers, 8 occupational therapists and 15 other health workers.

Table 1. (Continued)

2011 – Working in MoH in Gaza: 18 psychiatrists, 50 nurses, 30 psychologists, 17 social workers, and 2 occupational therapists. In the WB: in Gaza: 17 psychiatrists, 91 nurses, 15 psychologists, 22 social workers, and 5 occupational therapists.

• Trainings:

2004 – No specific trainings in mental health care.

2011 – Specific training in mental health care and development of postgraduate mental health programmes in different universities.

• Monitoring and research:

2004 – Basic system is in place.

2011 – An information system is being developed.

• Psychotropic medicines:

2004 – Essential drugs are available, but can be only be provided at the MH outpatients clinics.

2011 – There are pilots projects in some PHCC for GPs to detect common MH disorders, and to prescribe drugs.

• Mental health financing and budget:

2004 – 2,474,435.38 USD spend on MH services. It is 2.5% of health expenditures, from which 73% of it is used in the Psychiatric hospitals.

2011 – Approximately 3,400,000.00 Euros for MH services.

Sources: WHO-AIMS (WHO, 2009) Report 2005, Steering Committee on Mental Health (SOP) 2005, 2011–2013).

MdM agreed with MoH and WHO to begin work in one of the priority areas, Salfet, which is one of the 11 governorates in the West Bank (Table 2), and signed an agreement with the MoH for a pilot project to upgrade the skills of the mental health (MH) professionals, health staff and to improve infrastructure. In line with the key mental health needs of the Palestinians (see Table 3), the programme aimed to: 1) transform the existing outpatient clinic into a Community Mental Health Centre (CMHC); 2) recruit human resources, initially by MdM, that could be transferred to MoH after a given period of time; 3) provide capacity building, through training, for staff of Primary Health Care Centres (PHCCs) and in-service training for the Mental Health Team (MHT). The latter implied working on daily basis in the CMHC with the MHT to improve clinical and

organisational skills that could lead to a community based model for developing new services, such as rehabilitation and community awareness, and implementing working procedures in collaboration.

Mental health resources in the implementation area

Salfet Governorate is an area full of internal blockades created by different Israeli checkpoints, roadblocks and checkpoints. It has 16 settlements, and more than 10 settlement outposts. The Palestinian population is almost twice as large as the Israeli settler population (62,125 vs. 35,000). Construction of the wall is ongoing, and according to the Palestinian Ministry, if completed would take approximately 45.3% of the area of Salfet. This area is mostly rural, and exposed to land confiscation and violence arising from the occupation and internal

Table 2. Mental health system components addressed by the MdM intervention project

• Policy, plans and programmes:

Participating in the thematic group led by the Mental Health Unit to review the SOP 2004, from a technical aspect, in order to develop the next one.

• Outpatient clinics and CMHC:

Under consensus and agreement with the MoH, to reinforce MH care of PHC and MH structures in Salfeet. Under the frameworks of: SOP 2004, Inter-Agency Standing Committee (IASC) 2007 and WHO guidelines.

• PHCC from MoH:

The programme works towards integration of MH in primary health care. The attitude towards MH, and training needs of PHC staff was assessed and training given. Communication of MHT with PHC doctors and nurses was promoted.

• Advocacy:

A photo exhibition of mental health in the occupied Palestinian territories is being exhibited in different cities of Spain since 2009, showing the burden that people with severe MH disorders have to face, and also how political violence affects the human rights of Palestinians. Also advocacy was done to show the need for a psychiatrist to be available for more than one day a week, and on regular basis.

• Human resources:

A psychologist, an occupational therapist and a social worker were contracted to be part of the MHT.

• Training:

Trainings were provided for PHC staff, MHT of Salfeet, and also extended to MH professionals in the WB. In service training for the MHT was done, and there were also trainers for PHC trainings.

• Monitoring and research:

Register of information at the CMHC was improved.

• Psychotropic medicines:

Only once were some psychotropic drugs made available, as they usually run out of them for weeks, so relapses can be expected.

Table 3. Key points of mental health needs in the occupied Palestinian territories

- To increase quality and access to treatment, to decrease stigma and involve the community in the recovery process of people who have severe mental health disorders.
- To prevent, detect and treat common mental health disorders.
- A public health approach, based on the frameworks of social justice, quality of life, human rights and human security.
- A social and political response to the consequences of the conflict in the low quality of life and wellbeing of the general population.

conflict. With regard to mental health care services, in 2006 Salfect PHC Directorate had one full-time social worker, one part-time psychologist, and one psychiatrist visiting once per week. They shared one room, which made it difficult for some patients to talk about sensitive issues as all professional were there at the same time, and to define roles for the professionals.

Since the second Palestinian uprising against the Israeli occupation in late 2000 (the 'second Intifada'), curfews, army check points, road barriers, detentions, and the separation wall caused mobility problems, and many cases were treated with medication only, or remained untreated. The health care staff in the centre were used to a medical psychiatric approach, based on the prescription of drugs with limited psychosocial intervention. MHT at the PHCCs level received patients without an appointment system, and general practitioners and nurses rarely referred cases to the MHT. Despite this, Palestinian society has many protective factors that help maintain good mental health, such as the support and importance of extended family, a deep national feeling, and high literacy rates.

Why work with public institutions instead of local NGOs?

Armed conflict has long term psychological and psychosocial impacts that affect both individuals and community bonds (Martín-Baró, 1990). On the other hand, resilience and community capacity for overcoming negative impacts also play important roles. The involvement of communities and local authorities is important for successful multi-sectorial coordinated actions and sustainability in emergency settings (IASC, 2007). Policy makers can strengthen the services, as well as improve the legislation

to ensure the human rights of people with mental disorders. Communities can help in the recovery process, and be a source of support for mentally ill people and also for people who are under duress, but whose reactions are adaptive to the circumstances they face. The skills of the Palestinians professionals will remain, even if ministries face changes and they are dependent on external funding.

Mental health care programmes, provided by NGOs from developed countries in conflict or post conflict settings, often have a strong emergency perspective. Too often, the interventions that were started have to stop, once the immediate emergency is over. Moreover, such programmes can have the tendency to focus on mental health problems that have a direct relationship with the emergency, and may overlook people with severe mental disorders. Emergency programmes tend to work in relative isolation to the existing public system, and sometimes compete with it for scarce human resources. While short term mental health support is important, especially for vulnerable groups, the authors believe that the bulk of resources should be used to (re) construct community based mental health services. It is also important to lobby governments and funders to do the same, to ensure enduring access to care for people with pre-existing mental health conditions, as well as those who develop mental health problems as a result of an emergency (WHO, 2010).

The approach of MdM has been to create a strong partnership with the MoH, in order to improve the public health care service provision. Working with public institutions also allows continuity to the service users. Strengthening the general health care system will benefit those whose mental health condition is directly related to the conflict, as well as those who have a severe mental

disorder that is not directly related to it. MdM works to upgrade public health care services through empowering local professionals, enhancing local capacities, and community interventions that help restore the resilience mechanisms of individuals and the community. Additionally, in this particular project, working to reinforce the infrastructure, as the primary health care centres are often the first point of help for people with mental health and psychosocial problems.

Implementation of the programme

The programme strategy included: developing a CMHC; improving the access and quality of the CMHC in Salfeet; having individual, family, and community interventions; raising awareness; and being culturally appropriate. These goals are

necessary in order to meet the challenge of preventing and addressing MH needs in a population suffering from severe and common mental disorders, as well as the psychosocial problems that arise from conflict. This model was designed to respond to the current situation, and also to prepare the PHCC for MH problems that could arise due to a sudden escalation of tension (Figure 1).

The main components presented in the project, that were taken into account from the components developed in the SOP (above), are listed below.

1. At the CMHC level:

Provide infrastructures needed to develop a CMHC; provide technical support at the clinical and organisational level; train the staff; and increase human resources.

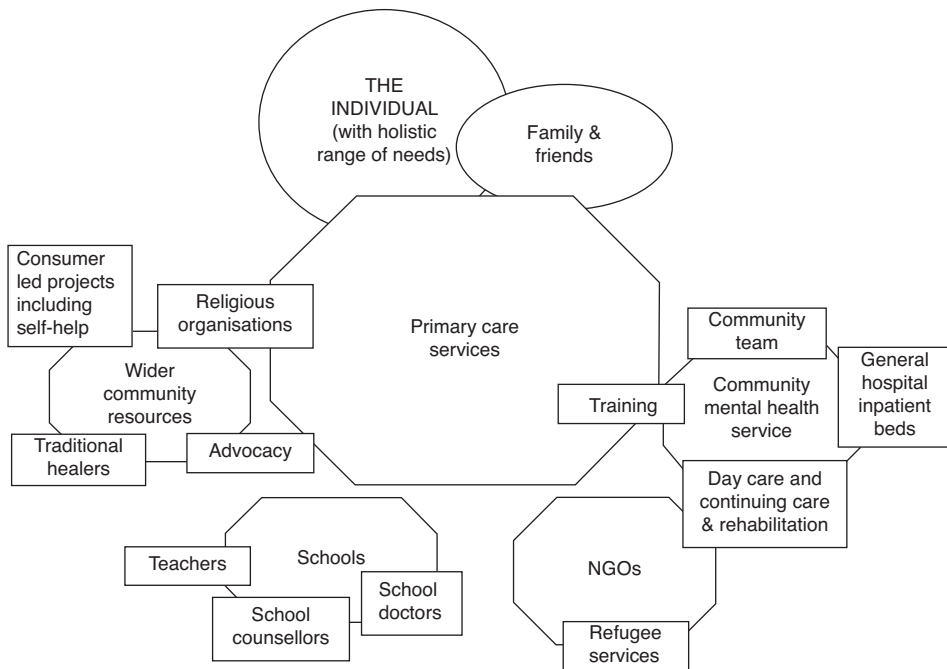


Figure 1: Components of a whole system of mental health care for individuals in the occupied Palestinian territories, based on the strategy of the SOP (Steering Committee on Mental Health, 2004).

2. At the PHC staff level:
Work on the awareness of health staff; train the PHC staff to increase their capacity to detect, help, and refer people with mental problems; and to make materials available to them.
3. At the community level:
Increase awareness in the community of mental health issues, media, and policy makers on MH; strengthen the partnership with other NGOs and UN organisations working in the field; build a holistic approach involving local organisations and institutions; link activities with schools; and provide support for families and caregivers.

Methodology

The programme was a participative effort involving members of the MHT, the director of the PHCC in the district, and the staff of the PHCC. The MHT underwent in-service training with an expatriate psychologist, who accompanied them on home visits, trained with local and international trainers, participated in awareness programmes, and aided in the translation and creation of materials in Arabic. An expatriate psychologist and a translator worked with the team on daily basis. The role of the expatriate was to follow up on the skills and knowledge given at the trainings, to provide technical support, and to facilitate the development of the service towards a community based care model.

This was done in two phases. The main difference between the phases was a greater emphasis on crisis intervention during the second phase due to the emergency situation in Gaza at that time.

First phase

The first phase started at the end of 2006, and lasted till September 2008. During this

phase there was attention focussed on the technical and organisational aspects, and training of mental health professionals (both through formal trainings, as well as through informal ‘on the job training’). The construction of a building for the Community Mental Health Centre was begun in this phase. In the meantime, a mobile clinic provided mental health services and a home visit programme was started. At the end of 2007, MdM hired a social worker, an occupational therapist, and a psychologist, on contract. After a year, these staff were transferred successfully to the Ministry of Health.

The staff translated training materials, such as *‘ICD-10 PC Diagnostic and Management Guidelines for Mental Disorders in Primary Care’* (WHO, 1996) and *‘Interview skills for psychotherapists’* (Fernandez-Liria & Rodriguez Vega, 2002).

The mental health team also trained general health workers in communication skills and started awareness raising activities through informative talks with religious leaders and local organisations. They also distributed brochures, launched a radio programme, and encouraged people with mental disorders to volunteer in community activities. Rehabilitation activities started in 2008 at the centre, and were developed by the MHT to extend into the community and involve patients in job creation programmes.

Second phase

The second phase lasted from September 2008 to October 2009, with follow-up occurring until September 2010. In this phase of the project, the socio-economic and security conditions in the area deteriorated. The siege over the Gaza Strip worsened the humanitarian situation because fuel and gas were not allowed into the Gaza Strip. In December 2008 and January 2009, during operation ‘Cast Lead’ – the Gaza

War, in which the Israeli army bombed and invaded the Gaza Strip - 1,380 Palestinian citizens from Gaza were killed. Many people in Salfeet had family in Gaza and were concerned about the situation. Additionally, at this time, local Israeli incursions into Salfeet district increased in frequency.

The programme adapted its activities to this new situation and provided mental health care information through the primary health care centres, school counsellors, and local organisations about healthy coping strategies. Additional training in crisis intervention was done for the PHC staff, and the programme released a booklet about crisis intervention.

In October 2009, the project ended. The foundations for integration of mental health care services into PHC structures were in place, and the Palestinian professionals could follow up independently.

Achievements

The MHT at the CMHC has become a reference in the West Bank for a community based model. Changing the attitude on mental health care was one of the many challenges undertaken, and an assessment among general health staff was done in 2007. This was repeated in 2008. In 2007, the staff perceived they had a low level of knowledge and training in mental health care and had feelings of fear and stigma about users with mental illness. In the second round of interviews, the self-perceived knowledge and skills were much higher than in the first round. Also, their attitude to mentally ill users changed, focussing more on respect and help than fear and stigma (Carreño et al., 2008). In addition, the MHT and PHC staff lobbied for service improvements and support of the integration strategy. The annual reports the team began in 2008 show how the number of new users to the mental health services

has increased over the years of the project, from less than 20 in 2007 to more than 140 in 2010. Additionally, visits to psychiatrists have increased from around 1,500 visits in 2007 to nearly 2,500 during 2010. The improvements in the documentation process are building a strong commitment with the services users, and families and communities are more involved in the recovery process, further demonstrating the success of the project.

The perception of the PHC Director of the governorate is that communication skills have improved in the PHC staff. Awareness of mental health issues also increased, as did the recognition knowledge of common mental disorders. WHO continues to develop these programmes and work in the district. The programme also established links with schools through the school programme of the MoH. In general, mental health is being considered as a more prominent and relevant concern in health care clinics, and the directorate of PHC takes an active role in disseminating information and involves the doctors and nurses.

Limitations and challenges

Some problems arose during the implementation of this project. Within the political context, the health care workers strike, and operation 'Cast Lead' in Gaza, affected the programme implementation. Another problem was that the professionals sometimes resisted implementing some new procedures that required a change from the previous manner of working. They were, for example, hesitant to record non-pharmacological interventions in the files, or to schedule follow up appointments.

MdM Spain initially focused on strengthening the MHT, and developing the services at the CMHC, as a way to empower the team and to prepare them to lead and continue the integration of PHC structures. Due to

the emphasis on the capacity building of the mental health team, some of components of integrating mental health care into primary care were not as well developed by the end of the project. For example, there were no regular meetings between the mental health team and the general health staff to review the cases of people who might have mental disorders. The referral system between the general health services and the mental health team needs to be improved. It proved to not have been possible to engage a psychiatrist for a minimum of two days per week, or to involve the psychiatrist in aspects other than the medical pharmacological aspects of service delivery. The authors tried to implement a family meeting in order to involve a large number of families in the recovery process and support them in understanding the illness, the relapses, and their role throughout this process. However, it was not possible to hold regular meetings until 2010, when this activity received the financial and technical support of WHO, which is supporting the Family Associations group in the oPt.

What we can learn from the experience in Salfeet?

In the humanitarian context, amidst conflicts and crisis, the challenge of developing the health care system lies in the professionals living in the oPt, specifically the Palestinian professionals working in the public health care system. The foreign NGOs should act as facilitators for this process and leave ownership of the programme to the local health care system and the local professionals. International aid can then be seen as an opportunity to improve or transform existing structures of the health care system, enabling them to deal with mental health problems during and after a crisis situation.

Using highly specialised trainers, who are often not available for long stays in the field, for the intensive activities, with longer deployments of more junior expatriate professionals, allows for good training and ensures follow-up and on the job training.

The role of international aid should be to support local people with respect, keeping in mind that one of the most undermining elements in conflicts is the loss of dignity. Dignity is important for both the local professionals, and for the population. As the professionals live in the same conflict area as the rest of the population, it is important to realise the complexity of the context where they live, and to recognise the importance of fostering resilience and coping skills. Dignity is also essential for users of mental health services. Their dignity is undermined not only by the conflict, but also by the stigma of having a mental disorder. Promoting self-respect and community awareness, addresses not only the mental illness but also the social suffering, and helps to frame a public health perspective into a human right approach.

The development of services is a continuous process. The project developed in Salfeet did not have a real end point. The Palestinian professionals involved in the project will still be present during the next few years to continue developing the services. The commitment, support, and understanding of mental health by the directors of PHCCs are therefore essential.

Political action can make mental health services sustainable in the oPt. Otherwise, the public health care system as a whole, and mental health care in particular, will not overcome its fragility, as it depends on donor funding. Working to restore normal life, dignity, and a context free of political violence is working for mental health.

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Scaling up of mental health and trauma support among war affected communities in northern Uganda: lessons learned

Florence Baingana & Patrick Onyango Mangen

In 2008, the local nongovernmental organisation TPO Uganda and the Uganda Ministry of Health began a project aimed of improving the availability of mental health services in three districts in Northern Uganda. The project consisted of: 1) training of general health workers in the primary health care system in mental health; 2) strengthening the capacity of the specialised mental health workers to deliver and supervise mental health outreach services; and 3) increasing the capacity of community members to respond effectively to mental health and psychosocial needs of people within their communities. The project provided assistance to 'patient support groups' that then provided support to patients with mental disorders. At the end of the 22 month project, the capacities of health workers and Village Health Teams to provide mental health services were strengthened. Major gaps, that still need to be addressed, were attrition of government health workers and a lack of drugs. Lessons learnt also include: the importance of coordination and joint planning between nongovernmental organisations and the government; the importance of support supervision; the important role of village health team members in community mobilisation and sensitisation; and the roles of patient support groups in complementing medical/clinical activities.

Keywords: evaluation, integration, mental health, northern Uganda, patient support groups, primary health care, village health teams

Introduction

Uganda is a low income East African country with an estimated population of 30.7 million (Uganda Bureau of Statistics, 2010a). 56% of the population is below 18 years old (Uganda Bureau of Statistics, 2010b). Over 80% of the population live in the rural areas, although the rate of rural to urban migration is high. The population growth rate is estimated at 3.2% per annum, and 31% of the population is estimated to be living below the poverty line. Uganda's gross national income per capita is US \$460, when using the Atlas conversion factor, and US \$ 1,190, when using Purchasing Power Parity method that calculates the purchasing power over a US dollar in the concerned country (World Bank, 2010). While health indicators have improved slightly since the 1990s, they are still poor as indicated by a maternal mortality ratio of 435 per 100,000 live births (Government of Uganda & UNFPA, 2010), an under five mortality rate of 137 per 1,000 live births, and an infant mortality rate of 75 per 1,000 live births (Government of Uganda, 2009). Communicable diseases contribute 50% of disability adjusted life years lost (DALYs) (Government of Uganda, 2010a).

Until 2006, northern Uganda had experienced two decades of a civil war perpetrated by the Lords Resistance Army (LRA). The

most affected victims of this conflict were the local civilians, in particular women and children. Communities were also affected in their entirety as their means of livelihoods were destroyed, social safety nets incapacitated and families forced to settle in internally displaced persons (IDP) camps. Several studies on the war note that the cult-like, indoctrinating ideology of the LRA, specifically targeting children, inflicted immense psychological torture and anguish on their victims. At the height of the conflict, 1.8 million people were living in IDP camps (Horn, 2009; Multi-Country Demobilisation and Reintegration Program (MDRP), 2007). As a result, 60% of the population in northern Uganda is categorised as poor, compared to 16% in the central region (Higgins, 2009).

There is a scarcity of research published on the process of implementing mental health care into primary health care (Flisher et al., 2007; Knapp et al., 2006; WHO & Wonca, 2008). This article therefore describes an evaluation that was carried out, as a way to document successes and challenges of integrating mental health care into primary health care, in a post conflict situation. The challenge is not just the scarcity of evidence on the process of integration, but also notes that implementing that process are not always smooth (Petersen et al., 2011). For conflict affected countries, an additional challenge is that while efforts are being made to better document the effectiveness of mental health and psychosocial programmes, there is often a tension between rigorous quantitative methodology, and using more qualitative and participatory methods. There is a growing consensus that qualitative participatory evaluations are valuable, as they may be maybe more representative of the voices and perspectives of the target populations and other

stakeholders (de Graaf, Jansveld, & de Jager, 2008; Töl & Jordans, 2008). While some project evaluations aim to measure impact in a quantitative manner, others aim to assess success and challenges of the *processes* in order to improve programme implementation. This article is based on a qualitative evaluation that was meant as: *a learning and management tool, a source of feedback to field workers and an opportunity for joint critical reflection on relevance of the programme with regard to the priority needs of the targeted populations*' (Kortmann, 2008).

Background

Mental health, psychosocial issues and conflicts

Mental disorders and psychosocial problems are the frequent consequences of armed conflicts (Baingana, Bannon, & Thomas, 2004; de Jong et al., 2001; Steel et al., 2009). Other common mental health consequences of armed conflict include: depression, posttraumatic stress disorder (PTSD) and other anxiety disorders, as well as alcohol and substance abuse. Psychosocial consequences of armed conflict can include increased levels of interpersonal violence (against spouses and children), early sexual activity, promiscuous sexual behaviour, increased teen-age pregnancies, petty crimes, and vandalism, among others (Boothby, Strang, & Wessells, 2006; de Jong, 2002).

An epidemiological survey carried out in 15 districts of Uganda in 2004 found rates of up to 50% for depression in one of the most conflict affected districts, compared to 8% for districts not affected (Kinyanda, 2004). A more recent qualitative study, also carried out in northern Uganda, found locally defined syndromes that correspond to depression/dysthymia, anxiety and behavioural problems (Betancourt et al., 2009). Other studies have found high rates of

PTSD, depression and anxiety disorders (Ovuga, Oyok, & Moro, 2008; Pham, Vinck, & Stover, 2009; Roberts et al., 2008).

The need to provide interventions for mental health and psychosocial problems associated with conflicts is recognised, not just to alleviate the pain and suffering, but also because mental health and psychosocial problems are disabling, therefore making any attempts at reconstruction futile (Baingana et al., 2004; Cardozo et al., 2004; Mollica et al., 1999; Mollica et al., 2001). Mental disorders have also been found to negatively impact efforts for reconciliation (Bayer, Klasen, & Adam, 2007; Pham, Weinstein, & Longman, 2004).

Presently, in northern Uganda, the environment of return from the IDP camps is still difficult, and poses several challenges to families, ranging from inadequate livelihood support, access to psychosocial support and mental health care. Consequently, the government is encouraging public/private partnerships, especially with nongovernmental organisations (NGOs), to deliver specialist interventions to improve quality of life, such as mental health care, psychosocial support and child protection. TPO Uganda has, over the past three years, supported the local district health services to scale up services that provide psychosocial support, increase access to mental health care and support families to overcome emotional distress.

TPO Uganda is a Ugandan NGO. It began operations in Uganda in 1994, with the aim of providing psychosocial support and mental health care to communities, families and individuals in conflict and post conflict settings. Services are delivered through a community and family oriented intervention model, which mainly focuses on identifying existing community support structures, traditional circles of support and systematically building their capacity

to identify and participate in supporting psychosocial and mental health needs. This support is focussed on: children in need of protection; survivors of gender based violence; children and families infected and affected by HIV & AIDS; and families whose socio-economic wellbeing has been incapacitated by conflict and/or any other disasters.

Organisation of health services in Uganda

Uganda's health care system is organised along the principles of primary health care (Figures 1 and 2). A Health Centre I (HC I) is the first contact point for patients, which is also called an Aid Post. There is frequently no physical structure, but relies on outreach activities regularly held under a tree, or in a community building. The next level of care, Health Centre II (HC II) has a small outpatient structure, however, no admissions take place. Health Centre III has one ward for females and another for male patients, as well as a maternity unit. The bed capacity is eight. Health Centre IV (HC IV) is often attached to a Health Sub District, found at every sub County, which is an important administrative unit. The bed capacity of 25 is larger than for HC III, as well as having a larger, more diverse and more specialised staff. This level has an operating theatre and should be able to perform Caesarean sections and surgeries, such as repair of hernias and fractures. The District Hospital is the next level of care. There are both medical and surgical wards with both male and female wings, as well as a children's ward. There is also a maternity unit and a theatre. The bed capacity at the District Hospital can be up to 100. The Regional Referral Hospital has a bed capacity of about 250 beds. There are 12 Regional Referral Hospitals in Uganda.

Health Unit	Beds	Location	Population	Existing
HC I	0	Village	1,000	2000
HC II	0	Parish	5,000	746
HC III	8	Sub-County	20,000	679
HC IV	25	County	100,000	127
Gen. Hosp.	100	District	100,000-1M	87
Reg. Ref. Hosp	250	Region (3-5 Districts)	1M-2M	10
Nat. Ref. Hosp	450	National	over 20M	2

Figure 1: Levels of care: Uganda.

Gen. Hosp. = General hospitals; HC = Health centres; Nat. Ref. Hosp. = National referral hospitals; Reg. Ref. Hosp. = Regional referral hospitals.

There are two National Referral and Teaching Hospitals, with bed capacities of 450 each.

Districts are responsible for implementation of the National Health Policy, planning and management of district health services, and data management (Government of Uganda, 2000). District Hospitals, and all health units below this level, are the responsibility of the Districts. Regional Referral Hospitals and the National Referral Hospitals are the responsibility of the Ministry of Health. All district level staff, which include all district hospital staff and below, as well as staff under the District Health Office is recruited, deployed, and remunerated by the District Service Commissions. Health worker staffing norms used for district level staff are the Local Government Staffing norms. Regional Referral Hospitals, National Referral Hospitals, as well as Ministry of Health personnel, are recruited and deployed by the Health Service Commission (Government of Uganda, 2005). Any intervention provided at the District level requires the agreement of the District authorities, while

activities carried out at the Regional Referral Hospitals are the responsibility of the Ministry of Health. This creates a challenge, as both levels of care then have to be consulted and kept abreast of developments. While it may be easier to get the Districts to recruit mental health personnel, if the position falls within the Local Government Staffing norms, this is more difficult at the Regional Referral hospital level. The reason it is more difficult is that it involves recruitment through the Health Services Commission, which is a more centralised process. Additionally, other inputs like funds for outreach clinics or medication maybe available at the District level, but then the Regional Referral Hospital staff cannot use them. So while the Regional Referral level staff may appreciate their supervisory role, they have problems in actually implementing it due to the above constraints.

An important element in the health care system is the village health team, as they serve as an important link between the community and health providers. Such a team consists of community volunteers,

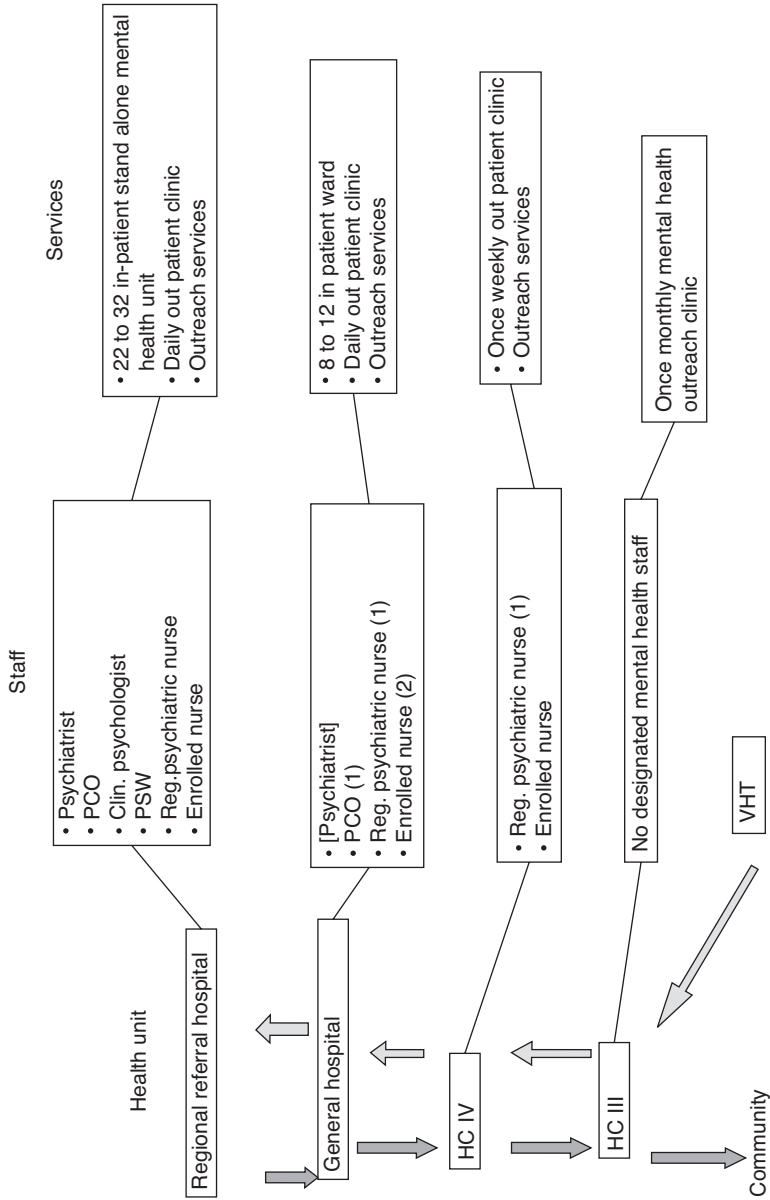


Figure 2: Organisation of the Mental Health Service: Uganda.

and has as responsibilities to identify the community's health needs and take appropriate measures. These can include: overseeing the activities of Community Health Workers, as well as maintaining a register of members of households and their health status (Government of Uganda, 2000). As of 2010, 75% of districts had formed village health teams, but only 31% of these districts had trained all village health team members in all villages. Village health team activities are also challenged by the very high attrition rate due to no, or poor, incentive/motivation systems (Government of Uganda, 2010b). Yet, village health teams play an important role in northern Uganda due to the severe shortage of trained health workers (Government of Uganda, 2007).

Mental health services in Uganda

In 1999, mental health care was included in the First Health Policy, as a component of the Uganda National Minimum Health Care Package (UNMHCP) (Government of Uganda, 1999). Mental health care is also included in specific sections included in the three Health Sector Strategic Plans (HSSP) (Government of Uganda, 2000, 2005, 2010b). The first HSSP had, as its main objective: *'to provide improved access to primary mental health services to the entire population, and to ensure ready access to quality mental health referral services at district, regional, and national level'* (Government of Uganda, 2000).

Every health worker has training in mental health provided in the basic, pre-service training. This means that, even at the peripheral levels of the health care system where there is no designated *'mental health'* worker, general health workers should be able to recognise and manage or refer common mental health problems. A manual for training village health teams in mental

health has also been developed (Government of Uganda, 2010c). Two specialised mental health workers are attached to an HC IV (Health Sub County), and more specialised mental health workers should be present at the District Hospital. A person with a mental disorder, who requires admission, can be admitted to either the male or the female wards at HC IV. The District Hospital is supposed to have a small unit for patients with mental disorders, with between 8 - 22 beds. HC IV is also supposed to run mental health clinics once a week, while District Hospitals should do this on daily basis.

Project description

The project was initiated in March 2008, and closed in December 2010. The project goal was stated as: *'mental health services are available to communities affected by conflicts and war trauma in Gulu, Kitgum and Pader districts in northern Uganda.'* The population of the district of Gulu is 374,700, that of Kitgum is 387,100 and the population of Pader is 481,800 (Uganda Bureau of Statistics, 2010b). Large percentages of these populations had been in IDP camps, but over the duration of the project, were slowly resettling back into their original communities. There is one Regional Referral Hospital in Gulu District. Kitgum has one Government District Hospital as well as a faith-based Hospital (St Joseph's Hospital). Pader District does not have a District Hospital, the highest level of care being the Pader Health Centre IV. In total, the facilities mentioned above, in the project areas, had nine qualified psychiatric nurses and eight psychiatric clinical officers (with training levels falling between that of a psychiatric nurse and a psychiatrist). There were no psychiatrists in any of these facilities. The project has three main objectives.

1. Building the capacity of health workers to recognise, assess and manage mental illnesses.
2. Strengthening the capacity of dedicated mental health workers to supervise and implement mental health outreach services.
3. Helping communities to appropriately respond to the mental health and psychological needs of people within the community.

The project was fully implemented through government structures. TPO Uganda provided funds for the training of health workers so they were able to recognise and manage common mental health problems. The NGO and the District authorities identified which health centres were to be included for outreach clinic activities. Through an outreach schedule, the identified Health Centre III and IVs were visited at least once a month by the psychiatric clinical officers or psychiatric nurses. The NGO employed social workers, who provided support to the Village Health Team Members, as they in turn supported patient support groups.

Evaluation methodology

The evaluation was done by the first author. Methodology included a desk review of TPO Uganda documents at the offices in Kampala, Gulu, Pader and Kitgum. In each of the three districts, field visits were made, and these were discussed and agreed with the Project Coordinator in Gulu District and the two Project Officers in Pader and Kitgum Districts. The focus of the field visits was on qualitative aspects. Ten days were spent in the field, carrying out field visits. In each of the three districts, key informant interviews were held with the three District Health Officers, with

the people in charge of health units, and with senior technical staff and partners of the project such as CARE Uganda and the Peter Alderman Foundation.

In each district, focus group discussions were held with beneficiaries, including patients attending a clinic, patient support group members, and village health team members. Visits were made to the sites where the patient support groups held their activities, in all three districts. There was also direct observation of: clinics in progress, patient support group activities, and of the facilities where outreach clinics were held.

Findings

There were three purposes to the evaluation, and the findings are grouped around each. Purpose 1 had three objectives. In each purpose and objective, achievements and challenges are discussed.

Purpose 1

Objective 1: Evaluate the built capacity of health workers in the districts of Kigum, Pader and Gulu to recognise and assess, and manage mental illness

Successes included: patients with mental disorders successfully treated; health units providing space for the mental health clinics; district authorities recruited and deployed mental health staff to work alongside NGO staff; and mental health drugs were requisitioned. Village health teams, needed to work alongside TPO Uganda and government staff, were identified by the communities and participated in the mobilisation of patients and the running of mental health clinics. Mental health patients presented in large numbers, and were evidenced at each of the clinics that were visited. Health workers were trained in the management of common mental health problems. The data collected by the project was included in the

Ministry of Health (MoH) Health Management Information System.

Challenges included inconsistencies, such as workshops held, but no workshop reports were written. There was also an attrition of government health workers trained by the project. Transport was another challenge, with one vehicle for three districts proving inadequate. Lack of medication was yet another challenge. TPO Uganda had budgeted, over three years, to support drug provision at a reducing percentage: 100% for the first year, 75% for the second year, and 50% for the final year. The MoH/Districts were supposed to have increased drug supplies as the TPO Uganda support decreased. However, the government did not honour this agreement. Therefore, often, the NGO staff would have to provide emergency drugs to prevent shortages. The project could only cover some parts of some districts of Acholiland while the whole area was affected by the conflicts. Additionally, refresher training for the health workers was not carried out, leading to attrition of personnel, as well as knowledge and skills of those who remained in the project.

Objective 2: Evaluate the strengthening of capacity of Gulu Regional Referral Hospital (GRRH) and selected HCIVs to deliver and supervise mental health outreaches

Outreach visits from GRRH were carried out regularly, including support supervision. There was a drop in the numbers of hospital visits from patients from the areas where the outreach took place. The outreach activities had effectively diminished the need for patients to go to a regional referral hospital because services were available closer to home. Monthly mental health coordination meetings, of all stakeholders, took place regularly in each district.

Objective 3: Evaluate community capacity to appropriately respond to the mental health and psychosocial needs of persons affected by conflict, especially those affected by war trauma

Achievements included 18 village health team members identified to provide support to the project. They played a key role in mobilising patients for the Outreach Clinics, providing support to the patients' support group, following up patients in the homes to make sure they were taking their drugs and that they were doing well mentally. Village health team members were trained how to mobilise communities, how to sensitise communities to mental health issues, and how to identify and refer patients with mental disorders. Patients support groups were formed and held regular meetings. Some of these groups successfully carried out income generating activities. One of the visited groups had successfully mobilised members to plant groundnuts, which had then been harvested. They were planning to divide some of the harvest among themselves for consumption, and the rest was to be sold so the group could purchase an ox and a plough, which they would then hire out, as well as for use in their own group gardens.

Challenges

While each village health team was made up of 12 members, only one was trained. This was not adequate to either cover activities. There was no documentation of training of the village health teams, nor the patient support groups. None of the activities specifically targeted children, including those in school, and yet this is the largest segment of the population in Uganda.

Purpose 2) Study and establish the efficacy of the service delivery strategies and the model adopted by TPO Uganda

Achievements

The main achievement was accessing mental health services available to the

population in the north. Community mobilisation and sensitisation was effectively carried out, so numbers of patients at the outreach and static clinics far exceeded the targets. Average targets per clinic were 120 patients, but actual numbers often exceeded 200. This project demonstrates that with the addition of minimal resources to support coordination, transportation, scheduling, drug supply, and motivation for health workers and village health team members, integration of mental health care into primary health care can be successfully implemented.

Challenges

Many of the TPO Uganda outreach clinics were linked to the IDP camps. As the populations return to their original villages, access to services is going to become a challenge.

Purpose 3) Formulate lessons learned in a manner that will improve and strengthen the design for the next phase highlighting areas of emphasis

The following lessons were learnt:

1. TPO Uganda had only eight full time staff allocated to the project, but they were able to facilitate district health workers to establish and run mental health clinics, including support supervision, community mobilisation and sensitisation, coordination meetings and support to patients support group. In this way, a small number of project staff could have a significant impact.
2. Quarterly coordination and joint planning, between TPO Uganda and the government ensured smooth operation of all activities. A common mistake NGOs make is to plan and implement alone, without involving the government. This is especially true when the NGO has the resources, and the government may not be seen as making a significant contribution. However, if capacity is to be built within the governmental sector, and if such programmes as this one are to be sustainable, then regular planning and coordination meetings are a must.
3. Support supervision is critical to successful integration of mental health care into primary health care. Support supervision is a frequently mentioned challenge to integration of mental health into primary health care, and yet it is one of the critical pillars. In Uganda, a recent survey found that support supervision is one of the two weakest elements in integration of mental health care into primary health care (Makerere University School of Public Health, 2010).
4. Involvement of village health teams is crucial to the success of community mobilisation and sensitisation. Barriers to mental health care can include knowledge of the causes of mental disorders, as well as availability of mental health services (Nsereko et al., 2011). In Uganda, while mental health services have been strengthened since 2001 through two African Development Bank projects, a huge gap still exists between projections of patients with mental disorders and attendance at health units (Government of Uganda, 2010a). The concept of the village health team was introduced in the first Health Sector Strategic Plan and reinforced in the second HSSP (Government of Uganda, 2000, 2005). This project demonstrates that village health teams are crucial to mobilisation of patients, for community sensitisation, as well as for the support provided to the patients support group. This is especially true, as Uganda does not have a strong social support system. Village health teams

have demonstrated, through this project, that they can take on some of the social work roles required.

5. Combining medical/clinical activities with social activities leads to better outcomes for patients. Formation and support of the patients' support group, who then provide peer-to-peer support to the patients and their carers, provide incomes to the patients and families of those with mental disorders, as well as providing some rehabilitation activities for patients contribute to better outcomes for both the patients and their carers.

Recommendations

- One major gap observed was that of children's mental health services. There is a need to strengthen activities that access services to school aged children.
- It is important to develop guidelines for training of village health teams, including how to form patients support groups, how to provide support to the livelihood activities, and how sensitisation and mobilisation is carried out. Manuals should be provided to the village health team members in a language they understand.
- Manuals should be developed that outline roles and purpose of the patients support groups, especially in relation to peer-to-peer support of the carers and the patients. Groups have to be properly constituted within a legal framework in order to benefit from government and NGO initiatives.
- Support supervision guidelines should be provided for both the clinical, as well as the social support, aspects.
- Training of more than one health worker per clinic, in order to deal with the problem of staff attrition. It is also important to have refresher training for the health workers, at least once every year.

- Future programmes need to train more than one village health team per village.
- MoH needs to revise the Essential Drug Kit to include mental health drugs at the lower level of care. It may also be important to initiate a system to reward health units that have all drugs on the Essential Drug Kit available.

Conclusion

Overall, the project achieved the aims and objectives that it had set out. Mental health was successfully integrated into primary health care, health workers and village health teams were trained and they supported the provision of mental health services. Village health teams were instrumental in community mobilisation and sensitisation. Patient attendance was observed to be high, and patients reported satisfaction with the services provided. The project was also successful in the social support provided to patients through the patient support groups. The activities of the patient support groups provided income to households with people with mental disorders, and have the potential to provide peer-to-peer support for both patients, as well as, the carers of patients.

Major challenges encountered include inconsistent agreement by the government health service providers, so drug supply was not always consistent, and mental health workers to run the clinics were not always available. The project was also challenged by a weak support supervision system, which could have potentially negatively impacted the quality of the mental health services provided, and the quality of the patients' support group activities.

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Announcement

New Psychological First Aid Guide for Field Workers

Humanitarian emergencies, such as earthquakes, extreme drought and war, can be just as devastating to people's psychological and social wellbeing as to their physical health. This year, on World Humanitarian Day, the World Health Organization (WHO), War Trauma Foundation (WTF) and World Vision International (WVI) announced the release of the *Psychological First Aid Guide for Field Workers* as a resource to provide immediate psychosocial support that meets international standards of best practice.

Psychological first aid covers both social and psychological support, and involves the provision of humane, supportive and practical help to people suffering from serious crisis events. For staff and volunteers called upon to help in emergencies, the guide offers information on the most supportive things to say and do for people in distress, how to approach a new situation safely, and how to support people in ways that respect their dignity, culture and abilities.

The *Psychological First Aid Guide* can be taught to humanitarian workers within one day for immediate use. It orients humanitarian workers and others in how to give basic psychological support; to listen without pressuring the person to talk; to assess a person's needs and concerns; to help ensure that basic physical needs are met; to provide and mobilise social support; and to protect people from further harm. It emphasises support and protection for people who may need special attention in crises, including separated children and adolescents, people with disabilities, and people at risk of discrimination or violence.

The guide was developed in order to have widely agreed upon psychological first aid materials for use in low and middle income countries. Endorsed by 24 international humanitarian agencies, it reflects the emerging science and international consensus on how to provide basic support to people in the immediate aftermath of extremely stressful events. The *Psychological First Aid Guide* will enable humanitarian and emergency workers from all over the world to provide basic, but vital, psychosocial support to people in acute distress, including helping distressed relief workers themselves.

The guide is freely available in PDF format on this link: <http://www.who.int/mental.health/emergencies/en/>

Click this link to order the guide in print format from the WHO Bookshop:

<http://apps.who.int/bookorders/anglais/detail.jsp?session=1&codlan=1&codcol=15&codech=819>

Integrating mental health into primary care in Africa: the case of Equatorial Guinea

***María Goretti Morón-Nozalea, Juan Gómez de Tojeiro,
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The Spanish Cooperation, through the nongovernmental organisation Sanitary Religious Federation and the financing of the Spanish Agency for International Development Cooperation conducted an assessment of the mental health care system in Equatorial Guinea in 2009. There was no specific mental health policy in place, and no formalised mental health care system. A National Mental Health Policy has recently been approved, and an implementation plan was made by the government and nongovernmental organisations. The plan focuses on integration of mental health into primary care, through capacity building and sensitisation. The implementation is still in the initial phase, and the scaling up process is expected to be slow.

Keywords: Equatorial Guinea, integration of mental health into primary care, scaling up mental health systems

Introduction

This article describes the experience of improving mental health services in Equatorial Guinea. Equatorial Guinea has not faced recent violent conflicts, or natural disasters. Nevertheless, the lessons learned in this process could be of interest in other, emergency contexts in Sub Saharan Africa. The Spanish Cooperation provided the first step of implementation of mental health services in 2009. The main actors involved in the process were the nongovernmental organisation (NGO) Sanitary Religious

Federation (FRS, Federación de Religiosos Sanitarios) with the financing of the Spanish Agency for International Development Cooperation (AECID, Agencia Española de Cooperación Internacional para el Desarrollo).

The FRS has cooperated in the country since 1979, focusing on health services implementation, and since 2003, mainly in the primary care system. The AECID, which manages and coordinates the Spanish Government budget earmarked for development cooperation (AECID, 19/10/2011), used the grant to NGOs as the main development assistance channel in Equatorial Guinea. In 2008, FRS and AECID strengthened an agreement to support the primary health care system to provide an opportunity for the stabilisation of development programmes.

Health professionals in the primary health care increasingly realised the growing need to treat people with mental disorders, while also recognising the insufficient resources to provide this service. In this context in July 2009 the Spanish Cooperation, through the FRS/AECID agreement, conducted the first situation analysis.

In this article, the authors present the main findings of the situation analysis, as well as the achievements and activities leading to implementation of a mental health policy.

The challenge of mental health in Africa

Neuropsychiatric disorders comprise 10% of the burden of disease in Africa (WHO, 2008). Mental disorders are also associated with poverty, marginalisation and social disadvantage. It is also an essential and inseparable component of health, as per the *Lancet* series on global mental health (Prince et al., 2007), as it interacts with other health conditions, such as cardiovascular disease, diabetes, HIV/AIDS or malaria. These are of great concern in Equatorial Guinea, as in other countries of sub-Saharan Africa.

However, because of the high rates of mortality from infections and malnutrition, mental disorders often receive little attention from governments, and are still at the bottom of the list of health priorities for policymakers (Desjarlais, 1995). There is no reference to a mental health care system in Equatorial Guinea in the published literature, the majority of studies of the African Region being from South Africa (Hanlon, Wondimagegn, & Alem, 2010).

The World Health Organization (WHO) emphasises in its *Regional Strategy for Mental Health in Africa* (2000) that mental disease is a major cause of disability, and furthermore, one of the principal problems in tackling this problem is the lack of reliable information systems in the majority of countries (Okasha, 2002).

Equatorial Guinea: the context

Equatorial Guinea is small country in West Africa, with a population of 659,000 people. It is composed of a mainland and five inhabited islands. The dominant ethnic group are the Fang. Other ethnic groups include the Bubi, primarily on the island of Bioko, Annoboneses from the island of Anobón, the Ndowe and the Bisios. The

official languages of the country are Spanish and French, and the other spoken languages are Fang, Bubi, Ibo, and Pidgin.

The country, a former Spanish colony, has been independent since 1968. In its first decade of independence, the country saw severe ethnic violence, in which thousands were killed and around of a third of the population fled to neighbouring countries. Since 1979, after a military coup, the country has been ruled by the same president. Although nominally a constitutional democracy since 1991, the 1996, 2002, and 2009 presidential elections, as well as the 1999, 2004, and 2008 legislative elections, were widely seen as flawed. The president exerts almost total control over the political system and has discouraged political opposition (BBC News 06/10/2011).

Around 61% of the population lives in rural areas (WHO, 2009). There was a strong migratory movement from the middle of the 1990s, with the start of the exportation of oil. The country is currently one of the biggest oil producers in Sub Saharan Africa. Equatorial Guinea is a middle income country, and ranks 127, from a total of 177 countries, in the Human Development Index (United Nations Development Programme, 2007). The Gross Domestic Product (GDP) is characterised by sustainable development during recent years, from US \$ 73.5 million in 1991 to US \$ 2,188.3 in 2002 (World Bank, 2009). Yet, the total expenditure on health as a percentage of the GDP is 2.1% (WHO, 2006).

There are three doctors and five nurses for every 10,000 inhabitants. The health resources are widely centralised, in spite of political attempts to decentralise, (a law on the transfer of service provision to municipalities was approved in 2003). More than two thirds of all professionals are clinical assistants. Only 14% are nurses, and 1%

midwives. Ten percent of the health care staff are doctors, most of them are foreigners, and 76% of them are based in the major cities, Malabo and Bata, where 39% of the population lives (Ministerio de Sanidad y Bienestar Social & Agencia Española de Cooperación Internacional para el Desarrollo, 2002).

There are two regional hospitals in Malabo and Bata, five provincial hospitals in the provincial capitals, 11 district hospitals in the district capitals, 35 health centres and 291 health posts. The Cuban cooperation, which provides international medical assistance to countries affected by natural disasters or armed conflicts since 1963, contributed a Medical Brigade to the country from 2000, composed of 154 doctors spread over 18 districts, and rotate them every two years. In 2003, Cuba supported mainly hospital care, while the Spanish focused efforts more towards primary health care. With regard to the centres and posts that are not supported by the Spanish Cooperation, the majority are not currently operating, despite the existence of infrastructures. This is due to a lack of human and financial resources, as well as low community participation and management issues.

Traditional medicine

The government recognises the practice of traditional medicine, but it is not widely integrated into the health care system, and there is no regulation of their products (WHO, 2002). The country has a legal framework for traditional medicine, an agency of management and national coordination, an association of traditional medical assistants and a general board of directors of medical assistants. No schools exist, but families pass knowledge from generation to generation, or rely on people with *'charisma'* and/or leadership capacity.

One main factor contributing to the widespread use of traditional medicine in the country is its accessibility in terms of human and geographic resources, and that it is firmly established in the belief system of the population. In the case of Equatorial Guinea, it does not appear that affordability is a factor because traditional medicine is not necessarily cheap. Costs for treatments can easily mount to approximately 30,000 Fc CFA (US\$65), amounting to 33.3% of the monthly minimum wage.

The healers in Equatorial Guinea can be divided in two groups. On the one hand, there are healers who utilise fundamentally natural methods that generally pass from generation to generation, and are considered by the population to be authentic, *traditional healers*. On the other hand, there are those who practise spiritualist rites and generally attribute their healing powers to supernatural causes, popularly known as *mimbilis*.

Two of the illnesses framed inside the spiritual domain are mental disorders: the Ev⁵ and the Kong. The Ev⁵ is known as the 'seat of secrets and mysterious or extraordinary forces in the Fang man. . . Is to be alive as bacterial or reptilian type that lives in the human womb. It is born within him or can be acquired' (Mbana, 2004). Often when someone is behaving in a strange way, the people around him would say he was possessed by the Ev⁵. The Kong, whose tradition extends to other countries of Sub Saharan Africa such as Cameroon, Gabon and Nigeria, are seen as *'living dead'*, and when a man *'converts'*, he suffers an extensive range of symptoms, such as nightmares, psychic problems, agitation and violence, frequent crisis of epilepsy, movements of the limbs, palpitations, fear and anguish.

Mental illness is popularly known as *'dementia'*, which does not correspond to the meaning of *dementia* in international

classifications. Often the *'dementia'*, is identified by the Fang as *'a poor state of mind'*. It is situated in the heart, rather than in the head: by referring to *'dementia'* the Fang say *akoan nnem*, meaning someone is ill or sick at heart (will), and not *akoan nlo*, meaning to be ill in the head, that only signifies headache in the physiological sense (Mbana, 2004).

Little is known about the way patients are treated when they arrive at a healing centre, and probably the process differs widely between healers. According to interviews with local health professionals, in the first instance it is often the family of the patient who seeks the services of a healer. Healers do not reveal information about the substances they use to treat patients, however, it is known that containment methods, such as chains or ropes, which are applied in cases of agitation, do not meet basic security criteria.

The mental health system: situation analysis

In July 2009, the Spanish Cooperation conducted a situation analysis in order to strengthen the mental health care system in the country (Morón-Nozaleda & Fernandez-Liria, 2009). Prior to fieldwork, a survey was conducted among the seven teams from primary health care and the 17 health centres supported by the Spanish cooperation. The survey consisted of 19 items, covering these five topics: 1) the demand in mental health care from primary care; 2) attention for mental healthcare from primary care providers; 3) the attitude towards the mentally ill; 4) access to psychotropic medicine and; 5) attitude towards further training in mental health care. The participation rate was only 31%, so no meaningful conclusions can be drawn from this survey. In regard to the low participation rate, it related almost entirely to not answering due to the *'lack of*

familiarity with mental health care and lack of coverage in that area'. The only exception to this was one of the centres.

As a guide for the fieldwork, the WHO *Assessment Instrument for Mental Health System Tool* (WHO – AIMS) (WHO, 2005) was used to collect the principal information. The methods of data collection were mainly qualitative. Semi-structured interviews were conducted with all team coordinators and health professionals, from a total of 15 primary health care teams, throughout the country. The researchers spent at least one day with each team, participating in the doctor/patient encounter and home visits to users and their families. Two focus groups were carried out, one with school teachers, to explore mental health care in children and adolescents, and one with women to explore mental health care in that target group. Although it was planned to conduct a group of users and their families, it was not possible for geographical reasons. There was also no possibility of access to prisons and the legal system. In depth interviews were conducted with policymakers, national health coordinators, representatives of the Cuban cooperation, and the two psychiatrists working in the country.

The main findings of the assessment are summarised in Table 1.

Burden of mental disorders and treatment gap

In the health centres where neuropsychiatric treatment is offered, mainly in Bata, Malabo and Ebebiyin, mental health consultations in 2008 accounted for 11% of total consultations, 47% were women and 53% men. Fifty five percent of the consultations were for people between 15 and 44. The most prevalent pathologies are epilepsy (32% of cases in 2008 in the coastal region) and schizophrenia (21%). There is great concern about alcohol abuse, as well as other drugs

Table 1. Situation Analysis

	Situation analysis (July 2009)
<i>Policy and legislative framework</i>	No mental health policy or strategic plan. Specific programme for alcoholism (in draft). Plan from the Ministry of Health on building two neuropsychiatric hospitals of 50 beds each (expected in medium to long term). No specific legislation. No specific financial resources have been allocated to mental health care. The budget for the construction of the neuropsychiatric hospitals remains unclear. Financial funding for physical disability and intellectual disabilities (still in survey phase).
<i>Organisation of mental health services</i>	No specific mental health services exist in the country. The two psychiatrists from the Cuban cooperation attend an outpatient practice in the hospitals of Bata and Malabo, and a health centre in Bata. No beds are available for neuropsychiatric patients in hospitals. There are Spanish nurses who attend neuropsychiatric patients in primary health centres, mainly in the one located in Ebebiyin, with a bed for acute inpatients. Traditional medicine is widely distributed throughout the country, and the perception of primary health care workers is that the mentally ill first seek treatment through traditional medicine.
<i>Availability of essential psychotropic medicine</i>	Only diazepam, phenobarbital and phenytoin are available at all levels, however, distribution is irregular. Availability of psychotropic medication (more than one kind of antipsychotics, typical and atypical, and antidepressants) in four health centres, obtained through cooperation, with large variability in stock.
<i>Human resources</i>	No Equatorial Guinean psychiatrists. There are two Cuban psychiatrists attending the General Hospital of Malabo and Bata, and surrounding primary care centres. One Equatorial Guinean psychologist attends the psychosocial programme for HIV/AIDs patients.
<i>Training, support and supervision</i>	No mental health care nurses. There is a medical faculty in the country. The specific training on mental health is 2,4%. No mental health training is provided in the nurses' training. There is no faculty of psychology (to come).
<i>Monitoring</i>	The health information system is distributed to all the hospitals and health centres, and supposed to be collected monthly at regional level. This is not actually collected on a regular basis, is not reliable and the rate of response is low. It includes an item about psychiatric consultants, but this is not usually reported.

obtained from the jungle: *banga* (marihuana), *eboga* and *ondin* (hallucinogen) and *mocuba* (stimulation). Incidence of suicide is not registered.

According to the data from the *World Mental Health Survey* (2004), it is estimated that in the continental region of the country 15,000 people (3%) would suffer from a severe mental disorder and around 49,000 (10%) from a mild to moderate mental disorder. Therefore, there is an enormous gap in treatment (98.5%), since just 896 patients received treatment, in the whole coastal area, during 2008.

The scaling up process

Towards a mental health policy

In 2009 and 2010, several consultations were conducted by the Ministry of Health in order to reach a consensus on the next steps in the implementation of mental health services in the country. Owing to the high commitment of the government, as a first step the Ministry appointed a Mental Health Responsible. After a workshop in May 2010, with the participation of representatives from the Ministry of Health, WHO, Cuban and Spanish cooperation, and professionals in the general health system, a first draft of the Mental Health Policy was presented and circulated for consultation, before being finally approved on November 2010. The policy is intended to be an instrument to guide the whole implementation plan, and its main goals are:

1. Promote legislative changes needed to achieve full integration of mental health care at different levels of care.
2. Define and implement a specific training plan on mental health care for each professional profile involved.
3. Ensure access to essential psychopharmacology, reducing the gap in treatment.
4. Reduce stigma and discrimination of mental illness among the general population and professionals, with development of awareness raising campaigns.
5. Improve the prevention of severe mental disorder and substances abuse, including early intervention and reduction of risk factors.
6. Define and implement a framework of coordination among all implicated sectors.

These goals aim to follow the international recommendations for mental health policy development in Africa (Gureje & Alem, 2000). The next step is to get approval for the strategic plan, with clear strategies and phases. Health staff and authorities have already designed a first draft. Without appropriate dissemination and operationalisation of the policy, its implementation is at risk of becoming weak and poor, as found in other countries such as Ghana or Zambia (Omar et al., 2010).

Integrating mental health care into primary care

Parallel with the policy development, from June 2010 the aspects of the project financed by the Spanish cooperation have focused on primary health care.

Primary care affords a better chance to promote accessibility and affordability, community awareness, and to coordinate with the traditional system (WHO & Wonca, 2008) (WHO, 2001). Obstacles and challenges are very similar to those in other low to medium income settings, guiding our efforts in relation to the WHO and World Psychiatric Association (WPA) recommendations (Thornicroft et al., 2010).

Few people suffering from a mental disorder, or their families, seek aid. In cases when they do, care delivery usually comes from traditional healers first. In these cases,

sometimes medical condition may worsen, and the dignity of the patient cannot be guaranteed (owing to use of restrictive and uncontrolled methods, such as chains and ropes). This pathway to care seems to be similar to other African countries, such as Uganda (Ssebunnya et al., 2010) and Nigeria, where the mental health care system is well documented (Eaton & Agomoh, 2008).

The main obstacles and achievements are summarised in Table 2. Data have been obtained from an update of the situation analysis, conducted in July 2009, and the consensus of the workshop held with all stakeholders in May 2010.

The main opportunities for integration are the health professionals' availability and interest, professionals in the FRS with special concern for mental health disorders and experience in the field, and the growing awareness and interest of the government.

The activities implemented at the moment are based mainly on capacity building and awareness raising campaigns. In September and October 2010, the Spanish offered specific courses to health agents, auxiliaries and nurses, which will be repeated on a cyclical basis. Health agents have undertaken training in sensitisation, case finding and referral to health centres. On the primary health care level, the staff is receiving training on the basis of diagnosis and treatment, as well as referral criteria to a specialist. Specialist professionals are developing clinical guides and protocols for every level of care, on the basis of evidence based packages of care, relevant in the literature (Patel & Thornicroft, 2009; WHO, 2010).

The Spanish cooperation sponsored a specialised outpatient facility at the end of 2010, where expatriate mental health nurses, belonging to the FRS, lead. The headquarters is in Bata, and it has rehabilitation

places. Trainer training courses are available in order to guarantee training and supervision in primary care, as well as clinical rotations of auxiliaries and nurses at the primary level.

Awareness raising campaigns are also taking place through radio programmes and vignettes representing the major mental disorders (schizophrenia, acute psychosis, mania, and depression), as well as covering alcohol abuse in schools and health centres. Child and adolescent advocacy is a great challenge in the medium term, especially in rural areas.

A regular back-up in terms of supervision by the most experienced health centres of other primary care settings is under way, although there is an absolute paucity of local specialists, and this needs a long term solution. The regular supply of essential psychotropic medication is another major challenge, as at the moment NGOs are the only supplier. Both of these issues are crucial to the sustainability and success of the implementation model (Hanlon et al., 2010).

Case finding and detection programmes are developing as the cornerstone of the interventions. One of the main concerns is the survival of severely mentally ill people, living in the large urban areas after expulsion from their own communities. Specific programmes must be available, such as assertive community treatment teams and community based residential care. The goal of developing community mental health services is to give people equitable access in the '*least restrictive environment*', and involve users and families in the process (Thornicroft et al., 2010).

Conclusions and future directions

The mental health system in Equatorial Guinea is in its very early stages. The greatest

Table 2 Obstacles and achievements

Obstacles	Achievements and goals
No mental health policy, plans or programmes.	The first mental health policy was approved in November 2010. The Strategic Plan is in the approval and development phase.
Lack of training among general health professionals. Overwhelming the primary care system.	First specific training programmes for every level of care conducted. Clinical guides and protocols developed. Supervision and monitoring by more experienced professionals in primary health care in order to help them with care of neuropsychiatric patients.
Paucity of specialised mental health professionals.	Recruitment and training of specialised professionals: short term training courses; clinical rotations in foreign countries; long term specialist training.
Care delivery for neuropsychiatric patients is available in only four centres in the country.	Mental health integrated in general health care. Supervision from the specialised level. Case finding and detection in the community, through health worker training, mobile teams and coordination with the traditional medical practitioners and schools. Monitoring of chronic patients within the community.
No acute wards or any in-patient resources.	In the medium term, beds in district hospitals may be available for acute patients. Neuropsychiatric hospitals as reference system; in-patients admitted for short-term treatment and supervision of the community based monitoring.
Lack of legislation; stigma and discrimination; lack of effective advocacy.	Need to strengthen the protection of the human rights of people with mental disorders or illness, and their families, already one of the main goals of the policy. Development of specific legislation. Promotion of users and family associations.
Lack of awareness in the community. No prevention or promotion programmes.	Awareness campaigns through mass media and health education programmes at schools and in villages. Early detection of patients in the communities. Specific programmes for the prevention of alcohol and other substance abuse.
Widespread use of traditional medicine in the case of mental health conditions. Quality of care and respect of human rights are rarely guaranteed.	Coordination with traditional healers and integration in the training and awareness activities.
Distribution of essential psychotropic medication is irregular and scarce.	Essential psychotropic medication must be included in the essential medication list of the country, and government must guarantee the supply. Availability must be well defined for every level of care and professionals adequately trained.

Table 2 (Continued)

Obstacles	Achievements and goals
No public financing for mental health programmes.	Government must guarantee basic resources such as essential psychotropic medication supply. Budget must be decentralised.
The health information system is ineffective.	Basic mental health indicators must be collected (case detection and monitoring of chronic patients, availability of psychotropic medication, hospital indicators) and professionals must be trained in these issues. Prevalence research must be conducted at a national level.

challenges at the moment are the operationalisation of the mental health policy through an adequate strategic plan, and the development of specific programmes for the most vulnerable populations, such as children, adolescents and people suffering from severe mental disorders. Positive factors could be the established primary health care system, government commitment and the relative small size of the country. On the other hand, the neuropsychiatric hospitals due for construction by the government must guarantee a community care approach, which is not yet insured, and can suppose a risk of institutionalisation.

Close monitoring and regular evaluation of the implemented programmes must be a priority, in accordance with the international recommendations on scaling up mental health systems in low and middle income countries (Thornicroft et al., 2010), as well as the accumulated local experience.

Conflicts of interest

No conflict of interest.

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Psychosocial assistance and decentralised mental health care in post conflict Burundi 2000 – 2008

Peter Ventevogel, Herman Ndayisaba & Willem van de Put

In 2000 the nongovernmental organisation (NGO) HealthNet TPO started mental health and psychosocial support services in Burundi, a country that has been severely affected by civil war. Within a time frame of eight years, a wide range of mental health and psychosocial services were established, covering large parts of the country. During the programme period the NGO activities shifted from the delivery of direct services to capacity building activities aimed at embedding psychiatric services and psychosocial assistance within existing local health services and social systems. Among the strategies used were 1) training and supervision in mental health for government nurses and doctors in provincial hospitals, 2) training in psychosocial assistance and supervision of governmental social workers, and 3) building the capacity of psychosocial volunteers and local community based organisations. The handover of mental health and psychosocial services presented formidable challenges arising from difficulties for the state in sustaining mental health and psychosocial services within their systems, and from difficulties for users in contributing financially to the provision of services. Major lessons are that installing basic mental health within general care should be firmly rooted in a general health-system-strengthening approach and also that healing the social wounds of war should be embedded within an approach to strengthening 'community systems'.

Keywords: Burundi, community based psychosocial support, decentralisation of

mental health care, post conflict settings, sustainability

Introduction

Burundi is a small and densely populated country situated in the Great Lakes region in the heart of Africa, which has experienced cyclic outbreaks of violence since its independence in 1962. The major ethnic groups are *Tutsi* (an estimated 14%) who were historically economically and politically dominant, and the majority *Hutu* (an estimated 85%). Burundi is one of the world's most densely populated countries, with 206 persons per sq km (Bureau Intégré des Nations Unies au Burundi (BINUB), 2006) and one of the poorest countries, consistently appearing among the five least developed countries according to the Human Development Index (UNDP, 2011).

Several violent episodes led to considerable political and social upheaval, causing massive population movements and the destruction of social fabric throughout the country. In 1972, the *Tutsi* led government systematically killed approximately 150,000 better-educated *Hutus* after rebel attacks from neighbouring countries. In 1993, the assassination of the country's first democratically-elected president, a *Hutu*, was followed by massacres of unarmed *Tutsis* who were attacked by *Hutu* militias. This was followed by assaults on *Hutu* peasants by the *Tutsi*

led army. As many as 150,000 people died in the weeks immediately following the assassination (Wolpe, 2011). A protracted civil war erupted. The peace agreement in Arusha in 2001 diminished the violence and in 2005 democratic elections were held, but some rebel groups still remain active at the time of writing (2011).

An estimated 400,000 Burundians have been killed in the last few decades. Some 800,000 were forced to flee to neighbouring countries, and hundreds of thousands were internally displaced (Wolpe, 2011, BINUB, 2006). Development indicators show further deterioration during the period of war (1993–2002). The proportion of the population living below the poverty line (US\$2.15 a day) rose from 58% in 1993 to 89% in 2002, and the gross domestic product per capita fell from 524 USD in 1990 to 368 USD in 2005 (UNDP, 2011).

Mental disorders and psychosocial problems in Burundi

There are no published prevalence figures for mental disorders and psychosocial problems in Burundi. Based on rough estimates by the WHO we can assume that, as typical of other humanitarian emergencies, around 3–4% of the population will have severe mental disorders such as psychosis, bipolar disorder or severe depression, and around 10–20% will develop mild forms of mental disorders including mild to moderate depression, anxiety disorders, substance-use disorders and post-traumatic syndromes (van Ommeren, Saxena, & Saraceno, 2005). The prevalence of epilepsy is thought to be high in Burundi due to the abundant presence of risk: etiological factors include head trauma, obstetric complications and infectious diseases with neurological sequelae, such as cerebral malaria and parasitic worm

infections (Nsengiyumva et al., 2003; Yemadje et al., 2011). People in Burundi tend to associate epilepsy and severe mental disorders with supernatural causes and often seek help outside the health care sector (Nsengiyumva et al., 2006). An unpublished study by the authors to identify local idioms of distress shows that Burundians distinguish between several types of ‘*mental problems*’. The word *ibisazi* indicates a state of chronic confusion and is often used to indicate severe mental disorders. An important state of mind is *akabonge*, which literally means *sorrow* or *melancholy*. Other words that are used to indicate ‘*a state of sorrow in which a person is not able to function normally*’ are *agahinda* or *kinemuraakarunga*. In the descriptions of these states, several elements of the psychiatric concept of depression can be found: a subdued mood, loss of pleasure or lack of interest, loss of concentration and suicidal thoughts. The neglect of social obligations is an element that is stressed: the person is not interested in anything in the surroundings and is not able to play a useful part in life. Another expression is *ubwobabwinshi* which indicates fear, and especially fear that is related to traumatic events during war. People also use a specific word for epileptic seizures, *intandara*.

Warfare and conflict also lead to social problems, including sexual violence and the erosion of traditional mechanisms for social support and conflict resolution. As described in neighbouring Rwanda (Richters et al., 2008), traditional forms of mutual self-help were undermined because the social fabric of society was damaged. People in the same neighbourhoods did not trust each other any more and had lost their faith in institutions (Sliep, 2004). Generally, Burundians have developed a profound cynicism and distrust toward the state (Uvin, 2009). In

Burundi when talking to people one can hear complaints such as:

People do not help each other any more. They do not help each other if their neighbours have problems. They do not like to give advice to each other (as is our custom). People have become selfish. (Focus group of unskilled house-boys and babysitters in Bujumbura Mairie).

Overview of the development of the programme

In this context of poverty, lack of basic needs, damaged social fabric and neglect of mental health issues, the international nongovernmental organisation (NGO) TPO (Trans-cultural Psychosocial Organisation, after 2005: HealthNet TPO) successfully applied in 2000 for funds from The Netherlands government to begin a programme which would provide psychosocial and mental health services to the war-affected population. Formal services in mental health and psychosocial support were hitherto almost non-existent. In 2000, Burundi had one psychiatrist (trained abroad) and no psychiatric nurses or psychiatric social workers. The country had (and still has) only one psychiatric hospital, with around 60 beds and no psychiatrist. The Faculty of Education at the University of Burundi started to train clinical psychologists in the late 1990s, but at the time there were no organisations in which these workers could be employed. The country has no school for psychiatric nursing or psychiatric social work. In 2000, the Ministry of Public Health had no section for mental health and no written policy or strategy documents in regard to mental health.

The psychosocial and mental health activities of HealthNet TPO started in 2000 as

a pilot project in the capital, Bujumbura, and its surrounding provinces, and were based on a protocol, developed by De Jong and Komproe, which had been implemented in Uganda (Baron, 2002) and Cambodia (Somasundaram et al., 1999). The basic premise of the programme is that delivery of psychosocial and mental health services is of great importance for the empowerment and reintegration of vulnerable war survivors in post-conflict societies where, due to the destruction caused by war and displacement of population, the normal ‘healing systems’ have been damaged and the health care system has become dysfunctional (De Jong, 2002).

The programme in Burundi can be divided into three phases.

1. The first phase of the programme (2000–2004): initiating services

The programme set out to build a network of psychosocial and mental health services in communities in the city of Bujumbura and seven provinces in the country. In Burundi a province is usually small, with around 200–400,000 inhabitants. People with prior experience as social workers, teachers, nurses, or community development workers were installed as *psychosocial workers*¹ in the communities from which they originated. The ethnic composition of the team was balanced between the ethnic groups. Their training included six weeks of classroom training, followed by two weeks of field training, and then subsequent supervision and additional training courses. For more details about this training for psychosocial workers see Baron’s report (2002: 181–183) which describes similar training in Uganda. The psychosocial workers are employed by the NGO and form the backbone of the community based psychosocial programme, providing a broad package of services to

individual clients, their families and the communities.

They were engaged in:

- 1) Advocacy and awareness-raising among the general population and in specific target groups, such as internally-displaced persons, local leaders, government authorities, health workers and school teachers;
- 2) Supportive and problem-solving counselling of clients who presented themselves with psychosocial problems, mental problems or epilepsy. These consultations take place either in the 'counselling centre' (a small brick house with one or two rooms) or at the clients' homes;
- 3) Client referrals, as appropriate., to the relevant service institutions: health centres, the psychiatric hospital, the consultant psychiatrist (in the capital), social services, legal advice, local administration, and other NGOs (e.g. for assistance with income-generating activities or material assistance);
- 4) Developing and conducting group interventions and self-help groups for specific client groups, such as people with alcohol problems, relatives of epileptics, women vulnerable to domestic violence, people living with HIV/AIDS;
- 5) Facilitating sports, cultural- and recreational activities (mainly for youth), while at the same time providing opportunities to access psychosocial education and counselling;
- 6) Crisis interventions at the community level, e.g. in cases of domestic violence or neighbour disputes;
- 7) Supervision of community based volunteers who assist the psychosocial workers in mobilising communities and other tasks;
- 8) Networking and coordinating activities with other relevant stakeholders in the area: local administration, health and social action authorities, other NGOs, health service providers.

At the end of this phase, in 2004, 20 psychosocial workers were deployed (two or three per province, each given a target population of around 50,000 to 100,000 persons). All psychosocial workers could make use of a motorbike and a monthly fuel allowance which enabled them to cover two or three municipalities. Every two weeks the psychosocial workers of each area met with each other and their supervisors in a group to discuss new or difficult cases, thereby enabling them to learn about how to improve interventions by sharing their experiences. From the start through to 2008, additional training courses were organised according to specific themes including sexual- and gender based violence, and the use of specific intervention techniques such as narrative theatre (Meyer-Weitz and Sliep, 2005), as well as how to work with specific target groups. During the course of the programme several smaller separately-funded projects were added. They included projects for former child soldiers, for orphans and other vulnerable children, for survivors of sexual violence, for prisoners and for returning refugees (Nyamukeba and Ndayisaba, 2008). These sub- programmes functioned under the umbrella of the large programme that is described in this article. During the course of the programme research was done into traditional healing systems, and informal contacts were made between psychosocial workers and traditional healers. We chose to not formalise these relationships, with formal referral lines, but rather to maintain good relations on

an individual basis and to respect the choice of the client if they chose to get treatment from traditional healers.

In addition, a child focused psychosocial programme was set up in the provinces close to the capital Bujumbura since 2004. This latter programme was separately funded. It will not be discussed here as it has been described in depth elsewhere (Jordans et al., 2010).

Psychiatric services were provided through monthly mental health clinics that were held in provincial hospitals run by a team consisting of an (expatriate) psychiatrist and Burundian nurses employed by the NGO. They would see patients that were referred by the psychosocial workers, or (increasingly) that were self-referred. Given the absence of qualified psychiatric nurses in Burundi the NGO paid for the three year psychiatric nursing training of two Burundian nurses in Rwanda. Towards the end of 2004 mental health clinics by NGO nurses were organised in four provincial hospitals. These included on-the-job training of governmental nurses in these hospitals.

Reflections on this phase

The project started with the aim of providing services in a situation that was extremely fragile. Funding came from a single donor, under their budget earmarked for humanitarian emergencies. However, it must be remembered, that most people; within the government, the NGOs, and the general population, were unfamiliar with the concepts of community mental health care and psychosocial assistance. Much attention was given to developing *internal resource capacity* and ensuring *access to care* for those who were most in need. There was not much attention given to the embedding of our work in formalised systems. The project introduced NGO-based decentralised psychiatric

services and created a discipline that was new to Burundi, the psychosocial worker, salaried by the project, and with some basic skills to deal with a wide range of problems.

2. Second phase of the programme (2005-march 2007): searching for sustainability

The next phase of the programme was funded by the donor on the condition that it would outline a proper exit strategy and provide a plan to ensure sustainability of the activities.

During this phase HealthNet TPO employed three approaches to achieve sustainability of the psychosocial services and also developed plans with the Ministry of Public Health to anchor the psychiatric services within the government-run health care structures.

Community based psychosocial support

1. *Training psychosocial volunteers.* The initial approach of HealthNet TPO to the work of the psychosocial workers was, as in phase one, to train *community volunteers* who could take over a part of the psychosocial work. These volunteers would get regular supervision from experienced psychosocial workers. They were not paid, but would get some remuneration in the form of a bicycle and transport reimbursements for meetings. In 2005, the NGO's input to psychosocial assistance was reduced in the three western provinces where the programme had started. The number of psychosocial workers was reduced from three to one per province.
2. *Training social workers of the government.* In two new provinces in the north of Burundi, HealthNet TPO started an intensive cooperation with the Ministry of National Solidarity². In some provinces this ministry ran Centres for

Family Development (Centres de Développement Familiale CDF) staffed by social workers who were not trained in psychosocial assistance and were mainly occupied with reporting problem families and providing material assistance. A training programme for these workers was set up. Psychosocial assistance was integrated into the services of the CDF. During the first year the NGO provided 50% of the salaries, transferred equipment such as motor-bikes and computers and gave intensive supervision. At the end of the period the psychosocial care in these two provinces was handed over in full to the ministry.

3. *Training community based organisations*

In other provinces, the NGO interventions focussed less on direct service delivery and more on building capacity in local community based organisations such as women's groups, religious associations or youth associations. This entailed a dramatic reorientation of the role of the psychosocial worker, away from *'assisting people in difficulties'* towards *'enabling people to become more effective psychosocial helpers'*. In this new approach, psychosocial workers devoted much time to mobilising and training members of volunteer organisations, involving them in psychosocial activities, and assisting them in taking over direct psychosocial service delivery. Staff of these community based organisations would refer only the most difficult cases to the (more-experienced) NGO staff.

Services for people with mental disorders and epilepsy

The approach of the mental health component of the programme had three elements:

1. *Increasing the acceptance of treatment for mental health problems and epilepsy in the community*

Community mental health interventions included community-awareness workshops on mental disorders and the treatment possibilities, individual and family counselling and – when necessary – the referral of clients with mental problems by psychosocial workers and volunteers.

2. *Capacity building of governmental nurses and doctors*

HealthNet TPO was the lead-agency in the development of training materials for *'Mental Health into Primary Health Care'* drafted by a Technical Commission of the Ministry of Public Health (MSP, 2007). Agreements between the national ministry of health, the hospital directors and the NGO were signed. The provincial hospitals each appointed four general nurses to be trained in mental health, enabling them to dedicate part of their time to running the psychiatric service, and providing consultation rooms on the hospital premises. The NGO provided essential psychotropic drugs and equipment as well as training and supervision. The initial mental health training for nurses lasted 10 days, and was followed by a second training of 10 days, and a 5-day clinical apprenticeship in the psychiatric hospital. Courses were conducted by a Burundian psychiatric nurse and an expatriate psychiatrist. The trained nurses participated in the psychiatric services in their hospital under supervision of a psychiatric nurse from the NGO for at least 12 months, during which time they had group supervision meetings every two months in the capital. Each hospital only had one to three doctors. These doctors also received basic training in mental health (10 days)

so that they would be able to support the trained nurses.

3. *Engaging the national policy makers in the ministry of public health*

In this second phase, the NGO increased its efforts to engage national and local health authorities. HealthNet TPO and the Ministry of Public Health organised two regional conferences in Bujumbura to discuss the integration of mental health within general health care. Governmental and non-governmental representatives from Rwanda, Uganda, South Sudan, Tanzania and the Democratic Republic of Congo presented and shared their experiences around this theme. The World Health Organisation asked HealthNet TPO to carry out an evaluation of the mental health care situation in the country (WHO, 2007). This report has been the basis of a mental health strategy prepared by the government in November 2007. Several workshops were held with the ministry to develop their plan to decentralise the mental health services.

Reflections on this phase

In this phase, the NGO was aware of the need to install sustainable services while, at the same time, acknowledging that the country was recovering from a long civil war. During the period, elections took place and a consensus government came into office. Public institutions were rebuilt, but the reach of governmental services remained very weak and the level of public services was low. It quickly became apparent that creating sustainable psychosocial services through volunteers would be difficult. Although volunteers can play important roles in their communities, organisational strength at the community level is required. Incentives that keep volunteers productive

need to be developed and maintained by community-based organisations. Therefore working with community based organisations has greater potential because the intrinsic motivation of these groups is to support others. Such groups existed before the NGO intervention started and are likely to remain functional when the NGO ends its support. However, it remains doubtful whether problems of sustainability will be completely resolved by leaving community-based organisations with responsibility for the continuation of the activities.

The strategy of integrating psychosocial services work within governmental structures seemed promising at the start, and a fruitful collaboration with the Ministry of National Solidarity developed. However, in the longer term this ministry had a position that was too marginal within the government and demonstrated insufficient leverage to be able to sustain psychosocial services. An intensive cooperation with the Ministry of Public Health was developed in regard to psychiatric services. The provincial health authorities were very supportive and facilitated the installation of outpatient psychiatric services in their hospitals. At the national level, HealthNet TPO attempted to build interest by initiating conferences, working groups and developing materials with the government. However, the attitude of the government remained predominantly reactive.

3. *Third phase of the project: April 2007 – December 2008: handing over*

The last phase of the project focused on sustainability of the interventions through capacity-building, aiming to hand over services and integrate them within existing structures. In three provinces, the psychosocial assistance was integrated into the services of the Ministry of National

Solidarity. In the remaining provinces, the psychosocial workers worked with existing community structures. The role of the psychosocial worker was transformed into that of a trainer and supervisor who only assists in the more severe cases. Experienced psychosocial workers provided supportive supervision for a longer period before leaving the community volunteers and psychosocial workers of the ministry to deal with community awareness raising, promotion of support groups, and individual case-handling. Psychiatric care was integrated into general health care services of the provincial hospitals through psychiatric outpatient services (two days a week) provided by trained governmental nurses. The NGO continued to provide technical assistance, supervision, psychotropic drugs and adaptation of the health information system. In each provincial hospital, four general nurses were put through a training programme. Each nurse received two basic training courses of 10 days each, a clinical internship of five days, and a 'refresher' course of five days. The doctors of the provincial hospitals received an introductory training of five days with follow-up training. All training courses were part of a governmental plan to decentralise the mental health services and integrate them into general health care.

A national mental health strategy has been drafted and signed by the Minister of Public Health, and a national mental health policy

was drafted in 2007 by a multidisciplinary team with representatives of the Ministry of Health, the World Health Organization and HealthNet TPO. Monitoring and reporting tools have been elaborated by the project, and as a result of lobby six psychiatric diagnoses have been incorporated into the governmental health information system (See Box 1).

Separate trainings were held for officers of the Health Information System to include mental health data. As a result of a continuous lobby from the NGO the National List of Essential Drugs has been revised and now includes all basic psychotropic and anti-epileptic drugs from the model List of Essential Drugs by WHO, with the exception of long-acting depot medication.

Reflections on this phase

The handover of mental health and psychosocial services presented formidable challenges. It proved to be difficult for the Burundian authorities to sustain their commitments to continuing mental health and psychosocial services. The government was faced with severe funding problems and internal political instability that paralysed their decision-making. For example, from 2005 to 2008 there were four different Ministers of Public Health with varying levels of commitment to mental health.

The handing over of responsibilities to community based organisations has been

Box 1: Mental, neurological and substance use disorders newly included in the health information system in Burundi in 2008.

- Psychotic disorders
- Depression (moderate and severe)
- Bipolar disorder
- Epilepsy and seizure disorders
- Disorders related to use of alcohol and drugs
- Psychotrauma

successful in the sense that they feel empowered and respected and are proud of their involvement in mediation and referral, support and advice. Whether these capacities will last or need further strengthening is not clear. In her evaluation of the programme, Kortmann (2009) remarks that although help structures such as churches, women groups or traditional healers can give basic support they cannot provide all the psychosocial assistance needed. The assistance one can reasonably expect from these help structures are mobilisation of social support, providing emotional support, and mediation. This needs to be accompanied by: (a) a more specialised level of psychosocial assistance to which the community structures can refer in case of complicated problems; (b) ongoing clinical supervision and refresher courses and (c) a functional system of monitoring and evaluation.

Coverage and kinds of clients assisted: some data

Since 2003 the project has maintained an electronic psychosocial database registering the data about people who requested assistance from NGO psychosocial workers. 17,713 clients were seen by the psychosocial workers. The users of the services appear broadly representative of the population, although we did not register ethnicity because this is extremely sensitive in a

country with a history of ethnic violence. The clients requested assistance for (severe) mental disorders (21.5 %), epilepsy (35.1 %) and for psychosocial problems that were not related to these conditions (43.4%) (see Table 1). Once the initial psycho-education for patient and family was complete, the patient was given regular follow-up through the mental health clinic, and the psychosocial worker would limit his or her involvement to treatment compliance-enhancing activities.

People with '*psychosocial problems*' who did not have a mental disorder or epilepsy generally required the more active involvement of the psychosocial workers. A psychosocial worker worked with approximately 20-28 people showing such psychosocial problems per month. Family disputes, sexual violence, depression/bereavement/suicidal behaviour and health related complaints were the most frequent problems while psycho trauma, human rights violations and socioeconomic problems have also been presented often (See Table 2). From a psychiatric care perspective it is perhaps remarkable that relatively few clients were treated for '*depression*'. This reflects the way that psychosocial workers work; i.e. they work with the problems which the client presents and tend to avoid using labels such as '*depressive disorder*' or '*anxiety disorder*'.

The psychosocial problems clearly cover a wide range of problems and are, in fact, not

Table 1. Number of unique clients* seen by psychosocial assistants (2000–2008)

Type of consultation	Number of clients	Percentage
Psychosocial problems	7,695	43.4
Mental disorder	3,803	21.5
Epilepsy	6,215	35.1
Total	17,713	100.0

Each client was seen multiple times over the period, in case of chronic problems up to eight years.

Table 2 *Types of psychosocial problems* seen by psychosocial assistants (January 2001–November 2008)*

Type of problems	Percentage of total contacts (n = 7695)
Family disputes	20.8
Suicidalbehaviour/ depression/bereavement	13.1
Child abuse and other related problems	5.9
Sexual violence/rape	7.2
Psycho-trauma	5.9
Socio-economic complaints	8.1
Domestic violence	4.3
Complaints related to general health	8.1
Stress and psychosomatic complaints	4.1
Human rights violations/legal problems	3.8
Sexual/reproductive problems	3.6
Psychosocial problems related to HIV/AIDS	3.2
Spirit possession	1.0
Alcohol/drug abuse	1.6
Mental retardation	2.2
Community relations	1.5
Otherproblems	5.6
Total	100.0

Clients with a severe mental disorder or epilepsy are not included here.

very specific to the post-conflict setting but can be found in many African societies. However, it is likely that these problems are aggravated by ongoing insecurity, the loss of loved ones, the return of refugees and internally-displaced persons, and the break-down of social structures in the communities. A significant proportion of the problems presented to the psychosocial workers are not directly related to war or psychotrauma, but may be indirectly aggravated by the impact of war on the social structure and the reduced capacity of individuals and families to cope with their problems. The term *'collective trauma'* (Somasundaram, 2007) helps to better understand how a chronic war situation can lead to fundamental social transformations and affect the

psychosocial wellbeing and mental health of individuals.

A project-based computerised database for consultations at the mental health clinic started in 2006. From 2006 to 2008 the clinics registered almost 10,000 patients who received more than 60,000 consultations (see Table 3). The majority (65%) are people with epilepsy. About one quarter were people with psychotic disorders and 10% were people with non-psychotic mental disorders such as depression and anxiety disorders. The severity of depressive and anxiety disorders was not estimated, but the clinical impression of the first author, who worked in the programme from 2005 to 2007, is that the people with depression who were seen in the mental health clinics

Table 3 Morbidity among users of mental health clinics set up by HealthNet TPO and Ministry of Public Health in provincial hospitals (2006-2008)

	Number of patients	Percentage	Number of consultations
Epilepsy and other neurological problems			
• Generalised epilepsy	6,289	64	43,074
• Other epilepsies	58	< 1	281
• Neurological problems	31	< 1	121
Subtotal	6,378	65	43,476
Psychotic disorders			
• Schizophrenia	632	6	5,584
• Other psychoses	1,725	18	8,598
• Bipolar disorder	104	1	446
Subtotal	2,461	25	14,628
Other mental disorders			
• Depression	704	7	2,750
• Substance abuse	21	< 1	38
• Behavioural problems	65	1	253
• Others e.g. stress, anxiety	188	2	532
Subtotal	978	10	
Total	9,817	100	61,677

often had severe and disabling forms of depression. People with milder forms of depression and anxiety (i.e. that do not lead to major functional impairment) tended not to present themselves at a psychiatric service.

Discussion of achievements and challenges

It is rare that a long term intervention for mental health and psychosocial support in a resource-poor post-conflict setting is described. Eight years after the start of the project, mental health care services have improved. A mental health component was added, within 11 provincial hospitals, governmental nurses and doctors were trained, and large numbers of people were seen for consultations. The essential drug list was updated with psychotropic

medication and there was a more or less regular supply of psychotropic drugs to the hospitals. Initially the services were mainly used by people with epilepsy, but shortly thereafter more people with severe mental disorders (psychosis and bipolar disorder) presented themselves to the clinics, and gradually more people with severe depression sought psychiatric help. Community based psychosocial workers played a vital role as an intermediary between community and (mental) health services. They provided awareness-raising, psycho-education, referral and follow-up services, all of which are important elements of any effective programme for social psychiatry. The important ability to reach out into the community was, however, not subsequently continued by the formal health care system in Burundi.

The psychosocial workers were, however, meant to be more than auxiliaries to the health care system. From a community development perspective, the psychosocial workers who were actively involved in awareness raising sessions with the communities on various psychosocial problems, helped communities to define problems in ways that could relate to local resources *beyond* the health system. The psychosocial workers who were trained in the programme have become competent social agents through years of experience. They initially provided direct psychosocial assistance to people with all kinds of problems, initiated support groups within their communities, initiated recreational groups for youth, learned to intervene in crisis situations, and referred people to appropriate services within and beyond the health care sector. Later, they trained and coached community based organisations, and governmental social workers whose capacity was developed to deliver services for psychosocial problems.

Despite the good results described in this article there are still major challenges ahead that have not been sufficiently addressed to date.

1. Mental health and psychosocial support is insufficiently anchored in government policies and actions

The government has not been proactive with regard to mental health. A milestone in the development of mental healthcare in Burundi was the development and approval of a national mental health strategy, drafted in 2007. However, the document was only signed by the minister in 2010. Unfortunately the approval of the mental health strategy has not yet led to structurally increased government funding for mental health care. The

budget for mental health services remains around USD 55,000 or 0.43% of the total health budget. More than 90% of this modest budget is allocated to the country's only psychiatric hospital and covers its staff salaries. In the new health policy, 2010–2015 mental health is explicitly mentioned (which is an important realisation in itself) but a careful look at the proposed and budgeted activities shows that mental health is only mentioned twice (namely *'the need to update the strategic documents on mental health'* and *'the need to reinforce the training capacity of the National Institute for Public Health to provide specialised training in mental health'*).

The general stock of essential psychiatric drugs in the governmental distribution system is still insufficient, although the Ministry of Public Health pledged its expansion at the international Mental Health conference organised by the ministry and HealthNet TPO in January 2008. The difficulty in anchoring basic mental health care within official government policy reflects the low priority that the Burundian government gives to mental health, in common with many low-income countries (Jenkins et al., 2011). With hindsight, more time could have been invested in establishing the importance of mental health as an integrated part of health service provision. When the project started the plan to build-up the scope of the health system, in general, and in Burundi, in particular, was not as developed as it is now. As an organisation this should remind us of the importance of our investment in establishing policies which include mental health within general health-sector reforms.

While for mental health there is at least an approved strategic plan, there is no

such thing for psychosocial interventions based outside the health sector. A working group which included government personnel and HealthNet TPO staff met several times, but its efforts did not result in a national policy document that could put psychosocial assistance more visibly on the national and international agenda or attract internal and external funding. The Ministry of Solidarity has a *'charitable profile'* (e.g. paying for essential care of the very poor and vulnerable), but does not have well developed strategies to empower communities to care for themselves. HealthNet TPO has invested considerably in building the capacity of the Centres for Family Development (CDF) of the Ministry through training, material-support, and 50% salary payment before finally handing over the projects. The dependency on external support renders the CDF structures vulnerable. Many of these centres are now almost dormant and psychosocial workers at community level receive minimal support. The government has apparently not been able to honour the agreements it signed with the NGO.

2. *Financial sustainability of mental health and psychosocial services remains problematic*

Patients in the clinics that were set up by HealthNet TPO were asked to pay 1000 Burundian Francs (around 0.6 euro in 2011) per consultation and then received free medication. This fee was kept in a *'revolving fund'* so as to establish a buffer against the day that the NGO input ceased. Quite a number of people with chronic mental disorders or epilepsy could not afford this fee and often dropped out, even though the mental health clinics were usually lenient and did not deny treatment. Very few patients in Burundi have access to appropriate

health insurance for mental health care. Financial sustainability of the psychiatric services therefore remains problematic. At the time of the described project *results based financing* in Burundi was not yet implemented on a large scale. Including mental health services in such schemes may improve sustainability.

Achieving financial sustainability is even more problematic for psychosocial services. People in difficulties, who often have very limited cash and live at a subsistence level, will not easily be convinced into paying for an intervention that consists of *'just talking'*.

3. *Integration of mental health into primary care has not yet been realised*

Providing mental health services at the level of the provincial hospital is an important step, but should be followed by integration of mental health service at the health-centre level. This would make mental health services accessible to all. The data shown in Table 3 indicates that the psychiatric services in the provincial hospitals were mainly used by people with severe disorders such as epilepsy and psychotic disorders. The numbers of patients with common mental disorders such as depression and anxiety disorders were much lower than one would expect based on estimated prevalence. As has been described elsewhere in Eastern Africa (Muga and Jenkins, 2008; Nsereko et al., 2011), it is likely that many people with less severe mental disorders such as depression and anxiety do not self-identify as having a mental disorder and will not visit a specialised mental health centre, but rather present to the general health care system. Although the provinces in Burundi are small and the provincial hospitals can be reached within half a day on foot by almost all people, it

is not realistic to expect chronic patients to seek treatment on a monthly basis if it is far from their homes.

Future

Based on the experiences described in this article and similar experiences in other countries, HealthNet TPOs strategy for the next few years uses a *health system strengthening approach* together with a *community-system strengthening approach*. These should go hand in hand, but are not the same.

Strengthening health-systems

Burundi's health care system is undergoing major reforms in which decentralisation of the decision-making power (*autonomie de gestion*) is an important element and the introduction of Results Based Financing (RBF) another (MSP, 2011). It is important to ensure that mental health is included in these reforms. HealthNet TPO currently pilots the inclusion of mental health indicators in the healthcare programmes of the provinces of Gitega and Muramvya. As described above the sequence of interventions led us to work first on developing a set of skills that included elements of primary care as well as more sophisticated services (counselling, secondary care), and was then followed by attempts to embed these services in the system. An undesired effect of this approach is that mental health services were seen by the government as the responsibility of the NGO. An important lesson to be learned here is that the integration of mental health into the health system requires a systematic change in service delivery that should affect all units within the health system. A systematic approach to improving the conditions of work for health professionals, to financing models and to the governance aspects of organising services is needed.

Strengthening community systems

The initial strategy focused on training community based psychosocial counsellors to become a new professional group in a country where psychosocial assistance (at least as a professional intervention) did not exist. Learning from these lessons, the programme in Burundi changed its strategy towards strengthening the existing structures – public as well as more traditional and community based structures – not only in the interests of sustainability but also to reflect a cultural perspective and efficiency in terms of coverage: churches, women groups, healers, etc. Working with local resources for help and self-help requires a systematic approach to empowering local communities. This includes identifying existing (though sometimes dysfunctional) 'local resources' and helping to strengthen these existing help- structures in the communities. The approach may contain elements of *sociotherapy* (an approach that has been successfully tested in Rwanda, see Scholte et al., 2011) and the *family support conference* (Tankink, 2011).

Conclusion

We believe that integration of mental health at all levels of the healthcare, both secondary level as well as primary health care level, is necessary. It is the responsibility of the health care system to offer assistance to people with mental disorders, particularly those with severe and disabling mental disorders. However, health care services are not always best suited to assist people who have common mental disorders such as depression and anxiety disorders, whose aetiology is strongly related to social problems. We should therefore be wary of promoting psychiatric diagnostic categories as explanatory models for social suffering. For this reason we have learned to distinguish

community-oriented social psychiatry from community-building social work. This leads logically to a two-pronged approach; health-system strengthening alongside community-system strengthening. In our view, the installation of basic psychiatric services within general health care should be accompanied by activities to heal the social wounds of war.

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¹ Initially they were called '*conseillers*' (English: counsellors). However, the community based psychosocial work they are involved in is much broader than what is usually understood as 'counselling' and therefore the job title was changed into 'psychosocial workers', or in French 'assistants psychosociaux' (the latter indicating the broader psychosocial assistance that they are giving).

² Initially this ministry was called *Ministère de l'Action Sociale et du Genre* (Ministry of Social Action and Gender). In 2005, in a reshuffle of the ministerial portfolios most of this ministry merged into the new *Ministère de la Solidarité Nationale, des Droits de la Personne Humaine et du Genre* (Ministry of National Solidarity, Human Rights and

Gender). For simplicity, we use the term 'Ministry of National Solidarity' throughout this paper.

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Iraq and mental health policy: a post invasion analysis

Sonali Sharma & Jack Piachaud

The Iraq war, and the subsequent involvement of various stakeholders in the post conflict reconstruction of the health sector, presented an opportunity to learn about mental health policy development, challenges and obstacles within a post conflict context in 2003. This paper documents and explores mental health policy in post invasion Iraq, using qualitative methods and a health policy framework that analyses context, content and process. Findings indicate that there are many challenges, both in repairing an already weakened health sector, and in maintaining mental health as a health priority. In addition to security issues, fragmentation of power, change of leadership and lack of funding pose significant problems. Achievements are evident, though insufficient to address the overall mental health burden. The policy process is examined over a four-year period. Lessons learned are presented as best practice guidelines for post conflict mental health reconstruction.

Keywords: conflict, Iraq, mental health and complex emergencies, mental health policy, post conflict reconstruction, war

Introduction

More than 30 years of an oppressive regime, and the ensuing war in 2003, have devastated Iraqi society and imposed a large public mental health crisis on the population. Forced migration of over four million people, pervasive human rights abuses, and years of daily violence since the 2003 invasion, have taken a toll, both on the individual and on the society. Approximately 1.3 million internally displaced persons (IDPs)

are estimated to be in Iraq (UNHCR, 2011). In addition, almost 50% of the total Iraqi population is comprised of those below 18 years of age, posing a significant challenge for policy on mental health. Although the overall impact is unknown, the increased mental health burden is high, and demands that mental health policymakers adequately respond to the crisis.

In order to better understand the experiences faced in the Iraqi context, and to contribute to the dialogue on best practice guidelines for other states in transition, this paper will examine mental health policy development in post invasion Iraq.

Methodology

Because the study was initially conducted in the autumn of 2007, the period selected for review was 2003 to 2007. For this period, a retrospective qualitative case study methodology was utilised (an intensive analysis of a process which took place in the past using qualitative methods to study it), supported by literature reviews and key informant interviews, in order to gather data. Over 40 documents from scientific and peer-reviewed journals, newspapers, various institutions (including the World Health Organization (WHO), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), key nongovernmental organisations (NGOs) such as Medact, and donors, mental health institutions, academic institutions and unpublished 'grey' policy documents were collected and analysed. A

select group of international and Iraqi experts were surveyed, all with experience, either directly in Iraq or indirectly with post conflict health reconstruction in low and middle income countries. A snowballing technique identified potential interviewees. Of 35 people contacted, 21 responded (60%) and were interviewed over a six-week period in August–September 2007, either by telephone, or in person where possible. Interviews were conducted in English, using a semi-structured interview tool with 20 open-ended questions divided among the following topics: drivers and influences of mental health policy, planning of services, achievements in mental health, obstacles to mental health reform, effect of the war on the mental health burden, and the role of NGOs and other stakeholders. Of the 21 respondents, the group consisted of five civil society leaders in mental health service delivery, seven senior experts in policymaking for mental health service delivery, and nine mental health professionals, both from within and outside of Iraq, across six countries. Only three of these respondents were located (at the time of the study) in Iraq, due to security issues. Consumers were contacted, but all declined to participate due to personal security issues. Data obtained from key informant interviews was cross-referenced, and substantiated by written literature to ensure accuracy.

Methodology for data analysis consisted of thematic analysis on interview content, grey policy documents, and literature reviewed using Walt's analysis (Walt, 1994) as a framework for mental health policy analysis. Walt's analysis was chosen due to its framing of health policy within an economic and political perspective in low and middle income countries and its use across various countries and areas of health, including mental health (De Vries & Klazinga, 2006;

Stockwell et al., 2005). The framework organises thematic content into four areas: context, actors, content of policy, and process, and specifically examines the interaction between these four areas. This paper is organised into two sections on context and content/process. The authors utilised this methodology as a means to better understand various influences and factors in mental health policy development, post invasion. Because this paper was submitted a few years after the key informant interviews took place, an additional review of the literature was conducted to analyse the period since 2007, in order to have a more comprehensive and updated view. However, due to budget and time constraints, follow-up interviews of respondents were not conducted, and therefore not incorporated into the policy analysis.

Ethical considerations

A description of this project, and a request for informed consent, were sent by email to all respondents. Those in insecure environments with no internet access were briefed about the project by telephone. Personal information was not collected on participants, and all information obtained from interviews was anonymous, unless otherwise specified in the report. For participant protection, no protocol approval was needed for this study.

Limitations of our analyses

Limitations of the analysis include lack of consumers interviewed due to security issues and language barrier, under-representation of Iraq-based respondents due to insecurity and poor access to communication, exclusion of those who did not speak English; predominance of senior leaders and staff rather than mid-level respondents; and exclusion of those in insecure environments

or with poor access to telecommunications. In addition, observations by respondents are based on the period between 2003 and 2007 and therefore this study does not examine interviewee observations on changes in policy after 2007.

Background and context of mental health policy development

Following a bloodless military coup in 1968, the Ba’athists came to power in Iraq for almost four decades of totalitarian rule. Human rights abuses such as torture, assassinations, disappearances, detentions, forced conscription, and amputations were pervasive during this period (Amowitz et al., 2004). Although Iraq initially prospered under Saddam’s rule, the economy and civil society weakened with increasing militarisation of the country. Military expenditure rose from 19.4% of GDP in 1975, to 38.4% in 1985, peaking at 70.1% in 1981 (Al-Khalil, 1989).

Further conflict ensued with the Iran/Iraq war from 1980 to 1988, the invasion by Iraq into Kuwait in 1990 and 1991, and subsequent UN sanctions due to the invasion of Kuwait. Oil revenues, which had generously financed much of the social services in Iraq through the 1970s, ceased and health care costs were no longer met. The UN Oil for Food Programme began in 1996 in response to the crisis, and required that two thirds of oil proceeds were earmarked for humanitarian needs (UN, 2010). By 20 March 2003, when the invasion began, both from a socio-political and economic point of view, the region had weakened. As the invasion proceeded, further destruction took place, and internal displacement worsened with 402,000 persons displaced from 2003 to 2005 (IOM, 2007), and another 1.6 million after a shrine bombing in Samarra (ReliefWeb, 2008) (Table 1). In the 1960s and 1970s, the health care system flourished and was a model for the region with mental health services well serving

Table 1. General country information – Iraq

Geographical area	440,000 square km
Population	30.01 million (2008)
Population growth rate	2.2% (average over 2005–2010)
Population aged 0 to 14 years	41.1% (2009)
Main languages	Arabic, Kurdish, Turkmen
Number of governorates	18
Main religions	Muslim 97% Christian, or other 3%
Ethnic groups	Arab 75–80% Kurdish 15–20% Turkmen, Assyrian, or other 5%
Socio-economic:	Lower middle income group (World Bank criteria)
GDP	USD \$40.66 billion (2006)
Life expectancy at birth	59.1 years for males, 63.1 years for females
Literacy rates	54.9% men, 23.3% women

Country Information on Iraq (CIA, 2010). Health care system prior to the 2003 invasion.

the population (Sadik & Al-Jadiry, 2006). Good access to roads, sanitation, water, transportation and communications supported the health care system. The health care system penetrated both urban and rural populations, providing access to 97% and 79% of Iraqis respectively, before 1991 (WHO, 2005). Infant mortality rates were low. Health care was financed through the government, with services free of charge to the public.

The Iran/Iraq war, and the invasion into Kuwait by Iraq, increasingly constrained public spending on health care, and by 1991 total expenditure on health had declined, health care indicators worsened and health infrastructure had deteriorated. Health expenditure plummeted from 3.72% of the GDP, before the 1990s, to 0.81% of the GDP after 1997 (Iraq MoH, 2004). Infant mortality rates increased in the 1990s, with estimates of 500,000 child deaths (Lehmann, 2004).

In 1997, the system changed from a government funded scheme to a self-financing system in which the cost of care is shifted to the patient. Free health care ceased to the public (WHO, 2005). Despite hospital ownership by the Ministry of Health, health care became increasingly privatised.

Mental health system prior to the 2003 invasion

Mental health in Iraq during the Ba'athist period was a hospital-based, public model with an emphasis on long term institutional care. The government initially financed mental health care until the self-financing system was introduced in 1997. Many practitioners were forced into the private system, or fled as funding declined.

Mental health care was a low priority on the health agenda. Outside of the hospital-based system of care, psychiatrists had limited influence on national policy. The total mental health care burden prior to 2003 is

unknown, due to scarcity of data on psychiatric epidemiology.

When the invasion occurred in 2003, the mental health care system was already severely constrained in regard to public resources and human capital, and limited in its capacity to meet the demands ahead (Table 2).

Socio-cultural context

The stigma attached to mental disorders has remained consistent over time in Iraq. Context analysis reveals: 1) the large degree of stigma leads users to seek care from primary care doctors, internists and neurologists, rather than psychiatrists; 2) most users of the mental health care system are primarily the severely mentally ill; 3) there is great reliance on local religious and cultural healers for assistance; and 4) family and communities, rather than the system of care, often assume responsibility for treating mental illness. Furthermore, according to Sadik (2010), negative attitudes towards treatment, work, marriage and recovery from mental illness impact the degree of social inclusion, despite the fact that most of the Iraqi public understand the scientific underpinning of mental disorders.

According to a WHO report (2003), '*rural life in Iraq is strongly influenced by tribal traditions, long held norms and religious teachings*'. Iraqi civilians often seek assistance from local and religious healers as the first point of contact. Coordination is poor between traditional and allopathic systems.

The mental health system post 2003 invasion

Since the 2003 invasion of Iraq, the exact mental health burden is unknown. Lifetime prevalence of any mental disorder is reported at 18.8% (Alhasnawi et al., 2009). High rates of anxiety, depression and posttraumatic stress syndrome (PTSD) (Hussein & Sa'adoon,

Table 2 History of Mental Health Services: Timeline (pre) 2003

705 AD	First mental hospital in the world established in Baghdad
1927	Baghdad Medical School established and modelled on UK system
Early 1950's	Mental health services established in Iraq with two psychiatric hospitals established, both in Baghdad; Al-Rashad Hospital, a 1,200 bed chronic care facility and Al-Rashid Hospital (now Ibn-Rushid Hospital), a 74 bed facility for acute psychiatric care
1960s–1970s	Establishment of mental health centres and mental health units in hospitals, school mental health programmes and mental health promotion efforts
1980s to 2003	Wars and UN imposed sanctions; General decline in health services, many psychiatrists and other doctors flee Iraq, plans for mental health strategies blocked by regime in power
2003 (pre) invasion	A few weeks before the war in 2003, ex-regime released convicted forensic prisoners (people with mental disorder who were in jail) into streets
Immediately post invasion, 2003	Violence, looting, and destruction of health infrastructure further undermines health services; Al-Rashid Hospital, the 1,200 bed chronic care psychiatric facility, was hit particularly hard Many international NGOs entered the scene out of goodwill to assist with humanitarian needs

From: Sadik & Al-Jadiry, 2006; U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), 2005.

2006; WHO, 2007) are documented. Among children, 47% experienced traumatic events from 2004–2006 (Razokhi et al., 2006) and high exposure levels to traumatic events correlate with mental, behavioural and emotional issues, with prevalence rates of 10–30% for posttraumatic stress disorder (Dimitry, 2011). In Mosul, 37.4% of children and adolescents in primary care centres were found to have mental disorders (Al-Jawadi, 2007). Suicide rates among young women in Kurdistan are increasing. Substance abuse has escalated with lifetime prevalence at 0.9% (Al-Hasnawi et al., 2009). Reasons cited include: conflict, economic strain, geographical location (bordering countries with high rates of abuse and

poor border control), weak oversight of pharmaceutical system resulting in a high rate of prescription drug abuse (Aqrabi & Humphreys, 2009). Opiates are widely used. Cocaine and cannabis are also available. Alcohol, although historically banned, is on the rise as well.

The mental health system remains two-tiered, with 92% of psychiatrists working both in public and private services, 2% in government only, and 5% solely in private practice (WHO, 2006). The public system transitioned from a self-financing model to a centralised one. Fewer than 100 psychiatrists, and minimal ancillary staff, serve the entire population of 27 million, or 1.6 professionals in mental

health facilities per 100,000 (WHO, 2006). Multi-disciplinary practice is virtually non-existent. There is no social insurance and no community residential facilities. The availability of mental health services for children and adolescents is very limited (Al-Obaidi, Budosan & Jeffery 2010).

Most inpatient psychiatric treatment is for severe and persistent mental illness. Mood disorders are treated on an outpatient basis. A biomedical model of treatment is in use. Mental health in primary care is limited. No support exists for consumer groups or families (WHO, 2006). Medications are frequently unavailable.

Mental health policy development: content and process post 2003 invasion

The analysis reveals that the content of mental health policy development remained fairly constant over time, but the process was continually challenged and thwarted by obstacles. The impact on government planning, action and policymaking is often an indirect consequence of conflict (Ugalde et al., 2000).

Key components of mental health policy development in Iraq, post 2003, include:

- Lobbying, strategy and planning at the Health Ministry level,
- Prioritisation of mental health care on the health agenda,
- Shift away from long term institutional care towards public and primary mental health care,
- Equitable distribution of access to care,
- Emphasis on capacity building, and
- Reliance on international collaborations.

The process of mental health policy development depends strongly on the governing body in power, public mental health leadership, and foreign support. Security issues

and sectarian violence, lack of coordination, competing models of mental health, corruption, stigma and culture, posed grave difficulties in moving the agenda forward. Key points, both with respect to content and process, will be discussed below.

Political transitions challenging the mental health agenda

Political transitions of power within Iraq, from 2003 to 2007, affected both the pace and timing of mental health policy development after the invasion. The four phases of government: 1) Coalition Provisional Authority (CPA) post invasion in 2003; 2) U.S.-led Iraq Interim Government from 28 June 2004; 3) Iraq Transitional Government from 3 May 2005; and 4) first elections on 15 December 2005, leading to an Iraqi cabinet and a four year government in March 2006; led to changes in leadership and lack of continuity of the mental health care agenda.

Health and public mental health leadership

Varied leadership within the health sector played a large role in both propagating and delaying a national strategy and implementation of mental health policies.

During the CPA's tenure, power struggles between USAID and the Pentagon initially led to a quick change of health leadership and delays. According to respondents, from the onset, there were missed opportunities, poor health sector planning, and lack of post conflict and regional expertise among management of the CPA (Medact, 2008, Chandrasekaran, 2006).

The first Iraqi Interim Health Minister and the CPA declared mental health care a key priority area in 2004 (Fleck, 2004). This declaration led to specific appointments, committees and achievements within the mental health care arena. The first mental

health budget was written for US \$2.5 million, or 0.32% of the total health budget from the CPA (Jones et al., 2006). Funds were put into mental health care training, psychiatric units in hospitals, and site visits. An Iraqi (expatriated) psychiatrist assumed the first position of National Advisor in Mental Health in February 2004. International collaboration, inauguration of a National Mental Health Council, and formulation of a comprehensive National Strategy ensued. By October 2004, a draft Mental Health Act was submitted and approved by the Cabinet. Although limited in its content, it put mental health care on the map as an integral public health priority.

After the one-year appointment of the National Advisor, the hands of leadership changed again and significant effort was required to keep mental health care on the agenda. High turnover of Health Ministers from 2004 to 2007, further fragmented mental health care policy efforts. The approved Mental Health Act was stalled. Receptivity was tested each time a new Health Minister came into power, and mental health care was not sustained as a consistent priority over time.

The current Minister of Health, Salih Al-Hasnawi, is a psychiatrist and he has maintained mental health care as a priority, with a particular focus on integration of mental health into primary care, as reflected in the 2009–2011 Health Strategy.

International collaboration and the role of foreign influence

Immediately post invasion, there was an outpouring of support and goodwill from the international community and the Iraqi Diaspora. The International Red Cross came to the rescue of the Al-Rashad Hospital, which was looted and damaged following the invasion (Humaidi, 2006). The WHO

has played an instrumental role in supporting the Health Ministry, convening expert consultations in Cairo in 2003 and 2005, and conducting epidemiological studies to better understand the mental health burden (Alhasnawi et al., 2009). WHO and partner agencies ensured that each Governorate had a refurbished mental health centre.

The U.S. SAMHSA collaborated with the CPA in early 2004, prioritised mental health on the health agenda, and mobilised SAMHSA resources (Curie, 2006). SAMHSA took the lead in convening two Action Planning Meetings in 2005 in Amman, Jordan (SAMHSA, 2006), and in March 2006 in Cairo, Egypt (Benderly, 2006). A multi-agency Iraq Planning Group was still in operation in 2007, with weekly conference calls and activities.

In the United Kingdom, the Royal College of Psychiatry convened an Iraq Sub-Committee in 2005, Annual Fringe Meetings and a volunteer scheme to bring mid-career level psychiatrists to Iraq for capacity building. A delegation to Iraq's Kurdistan region took place in July 2007 and established a formal link between the Royal College Volunteer Scheme and the Kurdistan Regional Governorate.

Many groups organised around the impending demand for mental health care and psychosocial services. Disenfranchised Iraqis, who had long standing concerns about the health sector, saw the invasion as an opportunity to help their country in the absence of an oppressive regime. There was an opportunity for free action that had not existed before. Iraqi psychiatrists in the UK established the Iraqi Mental Health Forum to provide supervisory and technical assistance, programme development expertise and supervision to young providers in Iraq. According to the nongovernmental organisation (NGO), Coordination Committee on

Iraq (2007), 80 international NGOs and 200 Iraqi NGOs were present as of 2007. A small proportion focused on mental health care. Unfortunately, many NGOs had to withdraw from Iraq, as a result of security issues, including death threats and killings of those providing services.

Capacity building through short term training was conducted outside of Iraq in collaboration with the UK, Kuwait and Jordan, in 2004 and 2005.

Financial contributions supplemented the Ministry of Health budget. In May of 2004, Japan donated USD \$6 million for mental health care services. The CPA requested from Congress USD \$850 million for health, with \$100 million earmarked for ambulatory care (Garfield, 2003). More recently, the Ministry of Health, with the support of USAID and IMC-Iraq, has been systematically supporting the integration of mental health care into primary care in 20% of basic health facilities (Sadik et al., 2011). Because of the success of the programme and the influence of donors, the Ministry will continue to fund and expand the programme to the rest of the country.

Competing models of mental health care

In response to a survey question on models of mental health care, respondents indicated that competing models of care were a source of power struggles within and between stakeholders. Health maintenance organisations (HMOs), centralised and self-financing models were considered. Policymakers endorsed reform and deinstitutionalisation of the inpatient psychiatric hospital, Al Rashad. In general, there was a lack of emphasis on the existing Iraqi health infrastructure and using local capacity to rebuild the system. The consensus for Iraq's model was a public mental health model with an emphasis on primary care, multi-

disciplinary teams, and links to community based care (Humphreys & Sadik, 2006).

Furthermore, the Iraq Ministry of Health Strategy, 2009 – 2011, emphasises primary health care as a main priority, with mental health care as one of the core initiatives (Iraq MoH, 2008).

Special populations at high risk for developing mental health issues, such as refugees, IDPs, children, women, and the disabled, have specific needs that should be considered in policy formulation for an appropriate model of mental health care. Child and adolescent mental health care is virtually non-existent, for example, and advocacy efforts around these issues call for increased support and policy steps (Al-Obaidi, 2010).

Sectarian violence in the health sector

Respondents repeatedly cite security as the major obstacle within the health sector. Sectarian violence and discrimination by political affiliation are widely pervasive throughout the health sector. Death threats against doctors, kidnappings, extortion and murders, posed a significant threat to the health workforce. Of the 34,000 doctors registered in Iraq before 2003, 17,000 fled, 2,000 were murdered and 250 were kidnapped (O'Hanlon & Campbell, 2007). The number of psychiatrists is purported to be below 30 for a population of 27 million. Postgraduate qualifications and training programmes in psychiatry suffer due to the severe shortage of mental health professionals.

Newspaper reports and respondents consistently allude to the Ministry of Health as a sectarian monopoly, teeming with corruption and involvement in alleged human rights abuses.

Corruption

Mismanagement of funding and private contracts thwarted reconstruction efforts.

Inefficient use of funds by private contractors has been well documented (Chatterjee, 2007; U.S. Senate, 2006). Lack of transparency, funding misappropriations and diversion of supplies to the black market are among the key issues contributing to further drains of the public system.

Stigma of mental health

The stigma attached to mental illness in Iraqi society is a barrier to mental health policy making. It influences the position of psychiatry within medicine, and affects demand for psychiatric services.

Implications of culture

Respondents stated that Iraqi culture is an obstacle in reaching consensus, working on teams and collaborating across ethnic factions. Political affiliation, past historical tensions and the removal of Ba'ath party members from positions within the Iraqi government after the invasion promulgated mistrust. Further ethnographic research is needed to examine culture as an obstacle in detail.

Policy recommendations

Policy recommendations can be elucidated from this analysis in post invasion Iraq, consistent with international guidelines and expert opinion. Presented below are a series of recommendations for post conflict mental health care, taking into consideration the context, content and process of policy development in Iraq.

- *Security is the first priority* in ensuring sound policy development. Insecurity fragmented the process in Iraq, and constantly posed a challenge.
- *Mental health care should be an integrated part of the overall health strategy* and focused on public mental health. A sustainable mental health care strategy is required that will

survive changes in leadership. Lobbying of ministers, political will, a clear national mental health plan and budget, as well as support from the international community, can all aid in this process. The strategy should include activities such as: integration of mental health care into primary care, building specialist mental health care, community-based mental health, and mental health promotion and outreach activities.

- *Coordinated mental health planning and programming is necessary* using international guidelines (e.g. IASC, 2007) and a minimum set of activities immediately post invasion, in addition to rapid needs assessments, multi-disciplinary teams, strategies based on need, and ensuring that all stakeholders are coordinated and working to support Ministry priorities.
- *Local capacity, resources and knowledge should be harnessed* to formulate a system that meets cultural needs and regional demands. Post conflict and regional experts should be consulted. Increased collaboration with the traditional community will enhance access and early identification.
- *Improved governance and management is recommended*, not only for mental health officers, but also for the overall health sector. Government performance standards, improved accountability and increased transparency measures should be put into place to the extent possible.
- *The mental health workforce should be expanded so that mental health services are maximally scaled up.* Targeting primary care providers to identify, treat and refer persons with mental disorders will provide direct access to a great number of people. Workforce expansion should include mental health training for primary care providers and support staff, including: psychologists, clinical social workers, psychiatric nurses,

midwives and paraprofessionals. Clinical psychiatrists can contribute by transitioning their role from clinical work to training and building capacity of basic service providers. Capacity building with clinical supervision should be the role of specialist teams. If capacity is limited, policymakers must be creative with local, regional or international expert supervisory teams. Coordination with other Ministries to make an investment in education, integrate mental health into pre service and in service training curricula, and to provide research opportunities, is recommended.

- *Investment from within the country is essential.* Transitional governments should enable and support local leadership, facilitate external experts working in conjunction with local expertise, and harness available resources within the country to promote the most culturally sensitive and appropriate solutions.
- *Efforts to reduce stigma, and a focus on mental health advocacy, should be integral to the overall health promotion strategy.* This can be achieved through mass media educational campaigns, awareness-raising activities, emphasis on primary health care and education and links with community stakeholders. Advocacy for mental health care should come from all sectors, and should focus on human rights. Development of consumer groups and family/caretaker coalitions can be advantageous in providing support.
- *Mental health care includes not only treatment of people with mental disorders, but also a deeper understanding of local risk and protective factors, and the development of targeted community and psychosocial interventions.*
- Although cited specific to the Iraqi context, *the culture of hierarchy* within medicine and across all disciplines relevant to health and wellbeing must be addressed

to promote an environment of teamwork, collaboration and trust.

- *The use of global networks and international expertise can be harnessed* in resource poor settings, however, in good coordination with the new government in power.
- *Links should be made with religious and traditional healers.* Capacity building, involvement in stakeholder meetings and education are some of the recommended activities among community leaders and healers.

The recommendations above are specific to this analysis of Iraq, and are also in line with expert opinion and international guidelines. This study demonstrates the difficulties of mental health policy development in a fragile state, but also highlights that progress can occur with a core set of activities and priorities. It is the author's hope that this analysis will provide insight to policymakers and practitioners in post conflict settings, and contribute to the development of mental health care in the most vulnerable settings.

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Jack Piachaud (passed away on 10 February 2009), was a clinical psychiatrist with over 20 years of experience in learning disabilities, was editor of Medicine Survival and Conflict, was involved with Medical Foundation for Care of Victims of Torture in the UK and was contributing to Medact's work in the UK.

Integrating mental health into existing systems of care during and after complex humanitarian emergencies: rethinking the experience

Pau Pérez-Sales, Alberto Fernández-Liria, Florence Baingana & Peter Ventevogel

This concluding paper of the Intervention Special Issue on integrating mental health care into health systems during and after complex emergencies summarises the main findings and conclusions of each of the programmes presented. This paper further integrates these findings into a common framework in order to extract key factors and recommendations on actions that can be taken, and those to avoid, to enable humanitarian emergencies to be transformed into opportunities in the psychosocial field. The main guiding principle to create such opportunities appears to require taking the post emergency context into consideration, from the first moments of any intervention. It is important that interventions in emergencies are conceptualised as part of the continuum of rehabilitation, construction and reconstruction. As a result, unique opportunities to rethink existing models and to introduce changes and new developments in the provision of mental health care and psychosocial support are created.

Keywords: complex humanitarian emergencies, lessons learned, mental health care in general health care

In the introduction paper of this issue, emergencies and disasters were defined as isolated or repeated situations that overwhelm the response capacity of a group or

a community. Furthermore, they cause major disruption and disintegration of the social fabric by preventing the affected population from functioning normally (Pérez-Sales, 2004). In the aftermath of an emergency, the need to rebuild offers unique opportunities for change: new leaderships may emerge, unconventional approaches may become a necessity and there might be a questioning of the status quo by parts of the society. Rebuilding from a disaster can also create a new way of thinking and an opportunity to redefine how the general and public services have been working. Additionally, there may be an influx of local and foreign qualified professionals, that also bring a new availability of aid funds. This combination of factors can turn a disaster into a unique opportunity for change that can truly stop the downward spiral of vulnerability associated with certain groups and communities (Anderson & Woodrow, 1998; Ventevogel, Pérez-Sales, Fernández-Liria, & Baingana, 2011).

In order to realise these potential benefits, it is important that mental health programmes in complex humanitarian emergencies have, from their onset, a clear focus on medium and long term development of community

based, primary mental health care services and social interventions. This is in contrast to the traditional focus on provision of immediate, short term relief of psychological distress during the acute phase of an emergency. This is also a key point in the brief published by the World Health Organization on mental health (MH) in emergencies (WHO, 2003). The same is true for other key points in this document: 1) The need for consultation and collaboration between governmental and nongovernmental organizations (NGOs) working in the area; 2) Continuous involvement, preferably of the government or local organisations is essential to ensure sustainability; 3) Encourage integration of mental health interventions in general primary health care (PHC); 4) Ensure access to services for all and avoid setting up separate, vertical mental health services for special population; 5) Make training and supervision a continuous process, by mental health specialists with sufficient clinical on-the-job training and thorough supervision and support of PHC-workers; and 6) start monitoring from the start of the activity.

This long term view implies a priority to initially develop a situation analysis of the existing (mental/psychosocial) health services in the area of the emergency. Such analysis needs to be sufficiently broad, and to include an exploration of how people cope, and what resources (not only material, but existing public services, community based organisations, religious institutions, traditional healers and other social institutions) are being used. This may assist the interventions in the first phase of the response to articulate a joint response, but will also help in laying the groundwork for a participatory process of reflection among local stakeholders about how the emergency can also be an opportunity for change.

Major international policy documents on MH in emergency settings by the Inter-Agency Standing Committee (IASC-RG., 2010; IASC, 2007), The Sphere Project (2004) and the World Health Organization (WHO & Wonca, 2008) advocate for the integration of mental health services within general health care services. Primary health care is defined as the first level of contact of the population with the health care system, carrying out tasks of health promotion, illness prevention, care for common illnesses, and management of ongoing health problems. Primary health care (PHC) services are usually the principal point of consultation for patients within a health care system, and depending on country conditions and the type of structure, can be carried out by a doctor, nurse, midwife, health worker, traditional healer, even members of the group or the community (WHO, 2005). In settings of complex humanitarian emergencies, a public health approach will often seek to transform the existing health system; aiming for increased access to services and social health protection, mitigation of the health effects of war (including social and environmental hazards), and increased and institutionalised participation of civil society in policy dialogue and accountability mechanisms. In displacement settings, it is often aimed at providing access to same level of care as the host population. There is a need for a global framework that requires reforms, in order to ensure that health care systems contribute to health equity and social justice. General hospital based MH services or community mental health centres are in an excellent position to provide the leadership, training and supervision that are essential for the successful integration of MH into PHC. However, these recommendations are not the reality in most countries.

According to the Mental Health Atlas, around 62% of countries in the world have mental health policies, 70% have some form of national mental health programme, 76% of low income countries provide some support of mental health in PHC, 55% have some treatment facilities for severe mental disorders in primary care, and 62% have some kind of community care facilities for mental health problems (WHO, 2005). It must be taken into account that simply having a policy plan, or a facility, does not automatically mean funding is available or that implementation occurs. Treatment in low income countries is often concentrated in a small number of places in the country, usually connected to, or around, large psychiatric hospitals. As a result, the vast majority of populations, living in low and middle income countries, do not have regular access to mental health care (WHO, 2005). International nongovernmental organizations (INGOs) and local NGOs operating in emergencies cannot ignore this reality, and should not pretend that their immediate relief efforts are aimed at restoring a 'normal', pre-disaster situation. There are some preliminary studies on the effectiveness of primary care mental health services in low income countries (Cohen et al., 2011) and in the decade that passed since these studies, more research has been done (Petersen, Lund, & Stein, 2011) and intervention packages for the treatment of mental, neurological and substance use disorders have been developed (Patel & Thornicroft, 2009). There have also been a number of important experiences of integrating MH in PHC during emergencies. Many of them have not been documented. There is an urgent need to document and evaluate what service models can deliver effective treatments and care, in a systemic fashion. This *Intervention Special Issue*

aims to take the first few steps to answer this need.

The widely diverging contexts in which humanitarian emergencies take place make it difficult to find common strategies, and to draw lessons learned that will be valid for all contexts. However, the experiences included in this issue refer to different situations that do have a common fact: that the community itself cannot cope and the resources to provide psychosocial support or mental health care to the population have become insufficient. Examples examined here include: the occurrence of natural disasters (such as in Sri Lanka, Peru or Haiti), the effects of chronic armed conflict on health care systems (such as in Uganda, Burundi, Peru, the occupied Palestinian territory or Lebanon), the influx of hundreds of thousands of refugees (such as in Syria and Lebanon) or a military rule and extreme inequality that hinders development (such as in Equatorial Guinea). The state of the existing mental health care system in these countries, described in this issue, is variable, as are the levels of human resources. For example some African countries, such as Equatorial Guinea, do not have a local psychiatrist, or very few in cases such as in Burundi with one psychiatrist for eight million people. In contrast, Lebanon (in the Middle East), has a much more developed mental health work force with one psychiatrist for 50,000 people. The functioning of general health services in which the mental health component needs to be integrated is also variable. There are countries in which the network of primary health care centres is very poorly developed (such as in Equatorial Guinea, Haiti or Burundi), and others where there is a reasonably functioning system for primary health care (such as in Uganda or the occupied Palestinian territory). Some projects occur

in countries with policies or mental health plans in different stages of development, and in others, without any pre-existing policies or plans. There are countries where there is an administrative system, such as a Ministry of Health, actively engaged as a partner with NGOs (Uganda), while in other countries the commitment of the government is much less strong (Burundi, Haiti). There are countries that have seen a huge influx of INGOs (Sri Lanka, Haiti, and the occupied Palestinian territory), while in other settings (Peru and Equatorial Guinea) there is far less support from the international community. In some settings coordinated plans of action have been developed between national and international actors (occupied Palestinian territory, Iraq, and Sri Lanka), while in others this is not the case (Equatorial Guinea and Burundi), or it has proven to be very difficult to coordinate (Haiti).

The first and second author (PPS and AFL) of this paper independently read the manuscripts contained here, and compiled a list of main components and key actions. They then collated their lists and compiled a draft list that was sent to the corresponding authors of all papers, with request to make corrections. The revised list was then verified by the last author (PV). The main components of each of the nine programmes in the eight countries described are summarised in Table 1. The two field reports in this issue (Ganesan, 2011; Jones, 2011) do not contain systematic descriptions of projects but reflect personal experiences of practitioners. These, and the mental health policy analysis of Iraq (Sharma & Piachaud, 2011), are not included in Table 1.

Beyond the differences, the experiences documented in this *Intervention Special Issue* have significant similarities. Although most articles do not report on outcome measures,

they do contain useful observations and lessons learned that allow an outline of some of the key components to create a successful programme for MH in general health care in complex humanitarian emergency settings.

The **general components and key actions** that can be found in one or more of the programmes examined, and which are associated with success by the authors, are described briefly below.

Coordination and collaboration

- It is important to establish a coordination group for mental health and psychosocial support (Sri Lanka, Lebanon and occupied Palestinian territories).

Assessment

- Interventions must be based on proper assessment of local needs. It is important to ensure participation of the local communities in participatory needs assessments to identify the main problems, how they have coped with these problems in the past, and how project intervention may help them to cope better with these problems in the future (Peru, Burundi).
- In the assessment, various kinds of stakeholders should participate to ensure that different perspectives are taken into account. This includes the participation of local authorities, the affected communities, future service users (people with mental disorders) and especially local health personnel (Syria, occupied Palestinian territory, Lebanon, Peru).
- Where there are no valid epidemiological data, conducting studies to determine the overall situation, and living conditions of special targeted groups, and provide rough estimates of prevalence. For example, people with severe mental disorder, people affected by political

Table 1. Summary of main components of each of the programmes

Aspects addressed by the intervention	Lebanon (Hijazi, Weissbocker & Chammay, 2011)		occupied Palestinian territory (de Val D'Espaux et al., 2011)		Equatorial Guinea (Morón-Nozaleida et al., 2011)		Haiti-1 (Budosan & Bruno, 2011)		Haiti-2 (Rose et al., 2011)		Uganda (Baingana & Onyango Mangen, 2011)		Burundi (Ventevogel, Ndayisaba, van de Put, 2011)		Peru (Kohan et al., 2011)	
	INGO	UN	Refugee crisis	Refugee crisis	INGO	INGO	Military Rule	Earthquake	INGO	Earthquake	Local NGO	INGO	Post conflict	INGO	Earthquake	INGO
Event that triggered the emergency situation	Refugee crisis	Refugee crisis	5/On Going	5/Finished	Ongoing occupation	1/On Going	2/On Going	2/On Going	2/On Going	3/Finished	8/Follow Up	4/On Going	✓	✓	✓	✓
Project duration (years)	4/On going	Not initially	Being done	Being done	Sub-cluster	✓	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster	Sub-cluster
Involvement in national MH policy development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Establishment of MHPSS Coordination Group	High	Medium	High	High	High	High	High	High	High	High	High	High	High	High	High	High
Level of government involvement and commitment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Participatory Assessment	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done	Being done
Advocacy for MH/PHC Policy Plans	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training of local human resources	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training of trainers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Learning through practice/on the job	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Network of volunteers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Strengthening community systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support for community mental health centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Establish referral systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

(continued overleaf)

Table 1. (Continued)

Aspects addressed by the intervention	Syria (Quosh, 2011)	Lebanon (Hijazi, Weissbecker & Chammay, 2011)	occupied Palestinian territory (de Val D'Espaux et al., 2011)	Equatorial Guinea (Morón-Nozaleda et al., 2011)	Haiti-1 (Budosan & Bruno, 2011)	Haiti-2 (Rose et al., 2011)	Uganda (Baingana & Onyango Mangan, 2011)	Burundi (Ventevogel, Ndayisaba, van de Put, 2011)	Peru (Kohan et al., 2011)
Adaptation of Health Information System		✓		Planned			Intended	✓	✓
Support to secondary/tertiary mental health care		✓		Planned		✓	✓	✓	✓
Case detection in community				✓		✓	✓	✓	✓
Case management	✓	Planned		Planned				✓	✓
Monitoring and research						Planned		✓	✓
Providing access to psychotropic medication (or advocacy for it)		✓	✓	Planned			✓	✓	✓
De-institutionalisation			✓						✓
Agreements for handover to local authorities		✓	✓			Intended	Intended	Intended	✓
Stigma reducing activities	✓		✓	✓ intended			✓	✓	
Collaboration with traditional/religious healers									
Output	Increased knowledge	Increased knowledge	Improved functioning health staff		Increased knowledge		Improved functioning health staff		Improved functioning health staff
Impact (according to authors)	Not assessed	Not assessed	High	Too early	Low	Low	Mixed results	Mixed results	Too early

MH = Mental health, MHPSS = mental health and psychosocial support, PHC = primary health care, INGO = International NGO, UN = United Nations Agency.

violence (Peru), and suicide in the community.

- It is important not only to identify the problems that should be tackled by the programme, but also discuss indicators of success with the community.

Programme design

- Programmes need to be designed with an *human rights perspective* (occupied Palestinian territory, Peru, Syria) and give specific attention to survivors of political violence (occupied Palestinian territory, Peru), and people displaced by violence and armed conflict (Lebanon, Iraq, Syria).
- In project design it is recommend using international consensus standards and guidelines, such as the *Sphere Handbook* (Sphere Project, 2004) and documents produced by the IASC taskforce and reference group for *Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007, IASC RG, 2010) to guide project activities (Haiti, Lebanon, Syria, Peru), but it is also important to build on local agreements and locally produced materials (Uganda, Lebanon, Syria, Peru, Burundi) that take cultural and religious aspects into account.
- It is important to have, *from the beginning*, a strategy for the *transfer* of responsibility to local stakeholders (occupied Palestinian territory, Peru, Equatorial Guinea, Uganda). It is also important to have specific agreements with the authorities about this transfer, although this is not always a guarantee that the handover will be successful (Burundi).
- MH interventions should be linked to other health and non-health interventions, such as nutrition programmes, livelihood activities, programmes for child wellbeing and protection,

empowerment programmes for women, etc. (occupied Palestinian territory, Syria, Burundi).

Structure of service delivery

- MH activities need to be installed on different levels of the health care system. Integration of MH into PHC is an essential element of such a multi-leveled system of MH services, but cannot stand alone. A coordinated network is required to make MH services accessible at the first points of access to the health care system, with ensuring appropriate referral systems between primary and secondary services (Lebanon, Syria, Burundi, occupied Palestinian territory, Uganda). Focusing only on the primary care level can lead trained general health workers to feel isolated, and it may discourage long term commitment.
- Access to health care for the *seriously mentally ill* should be guaranteed (occupied Palestinian territories, Peru, Burundi). This includes access to general (non psychiatric) health care services.
- Creation of community mental health centres, or other similar secondary health care resources, can be very useful. They act either as reference point for clinical attention, (i.e. occupied Palestinian territory) or as a technical point of referral, training and supervision of the network (i.e. Lebanon, occupied Palestinian territory, Peru, Uganda, Sri Lanka).
- It is essential to create or reinforce systems of referral and back referral (i.e. Lebanon, occupied Palestinian territory).
- Decentralisation from large hospitals is important. The World Health Organization recommends the de-institutionalisation of patients from psychiatric hospitals to community services. This often requires

the provision of beds in general hospitals (Lebanon, Peru, Iraq).

- Prescription of psychiatric drugs can be problematic. Some projects described how difficult it proved to change prescribing habits of primary care physicians (Haiti, Lebanon). This requires a strategy to avoid prescribing medication to those who could be feasibly helped with psychosocial interventions, and to ensure that for those with severe mental disorders and epilepsy, a continuous supply of medication is guaranteed (i.e. Lebanon, occupied Palestinian territory, Burundi).
- Proactive strategies of case finding and case management are important to ensure that patients with mental disorders are identified, and encouraged to comply to treatment. Case detection based on community networks is efficient and feasible (Peru, Burundi, Uganda). Case finding can be a problem in places where there are strong prejudices associated with mental health problems. Stigma, lack of knowledge of resources, geographical isolation, poverty and other factors can prevent the most severe patients from looking for care (Peru). Case detection should only be done when access to essential psychopharmacology and other forms of aid is ensured. *It is unethical to create expectations without guaranteeing conditions for treatment.*

Training

- Mental health training of primary health personnel is an essential tool for capacity building (this was described in all projects). It is important to use the principles and methods of adult learning and participatory training. It is important to acknowledge what participants already know, and to build on their experience. Training per se, without a framework

and a global plan, creates frustration and discourage people in the short term.

- Processes of training should ideally:
 - Use appropriate methods, including observation of standard practice, to identify training needs (Peru, occupied Palestinian territory, Haiti).
 - Be practice oriented.
 - Be related not only to transfer of knowledge, but also to accepted attitudes and approaches at all levels.
 - Provide training tailored to the recipient (often with different professional backgrounds, and who will work in multi-professional teams) (Syria, Lebanon).
 - Include on the job training and supervision. This is essential to instill clinical skills (Lebanon, Haiti, occupied Palestinian territory, Burundi).
 - Cascade training (training of trainers) can be considered if there is longer term support, monitoring and evaluation provided (Syria, Uganda, Burundi). However cascade training poses important difficulties for assessment, supervision and quality control.
 - Existing training materials such as the *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings* (World Health Organization, 2010) can be used in complex humanitarian emergencies (Haiti), but before that local materials should be made which are tailored to the local context, with attention to culture and idioms of distress (Syria, Lebanon, Haiti, occupied Palestinian territory, Burundi). Such locally produced materials are still valuable.

Working with the community

- Mental health professionals should understand and respect local coping

mechanisms for mental and psychosocial problems, and strengthen initiatives that foster mutual social support and self-help within the community (Haiti, Burundi). Projects can reinforce traditional ways of mutual self-help, but should also be careful not to ignore or undermine traditional systems by trying to introduce new ones with the idea of empowering the community.

- Locally designed psycho-educational materials, and workshops for the general population, are pivotal for success. Such interventions may target mental illness, stigma and discrimination, health habits (alcohol use, domestic violence, intellectual disability, severe mental disorder, epilepsy) and strengthen available resources for people affected with mental health problems (Uganda, Burundi, Equatorial Guinea).
- Collaboration with traditional and religious healers is a contentious issue. It is essential to learn where they are active, and what they do, and where appropriate to explore options of collaboration (Equatorial Guinea).
- Community and grassroots organisations should be seen as existing resources for collaboration (Burundi, Sri Lanka). Working with local authorities, natural or spontaneous leaders, community health workers, and psychosocial workers can be all be important to the sharing and support of activities (Burundi, Peru).
- Community based psychosocial workers or trained volunteers can be utilised for awareness raising and case identification, referral and follow up (Burundi, Uganda). However, volunteers need continuous support and supervision. On their own, they cannot provide the basis of a mental health system. Issues related to sustainability need to be considered, such as

financial remuneration of volunteers, ensuring of minimum quality, cultural acceptability, efficiency and coverage (staff attrition).

Lessons learned

These papers have made clear that the main, key component to create lasting and sustainable change across all projects and programmes is to include a long term perspective of inclusion of MH into PHC from the very start of any intervention. Several authors of articles in this issue expressed some dissatisfaction with the final results of the interventions. Table 2 summarises possible lessons learned, covering a wide range of issues, and includes key actions considered successful.

There are many sources of dissatisfaction, but the main one may possibly be related to the perhaps limited long term impact of some of the interventions. Unfortunately, this is something that cannot be assessed properly as the experiences documented here are primarily focused on satisfaction and activity/output indicators (like improvement in the level of knowledge of the staff that received training). There is a lack of outcome indicators in terms of the impact on the real life of people. Measures such as pre/post intervention indicators of the number of new cases properly detected and treated, measures of community and individual emotional wellness, number of cases properly included in case management strategies, or properly referred to other levels in a long term follow up, number of community cohesion activities or decrease in levels of violence or conflict in the community, are not routinely addressed. These measures are impacted by time or budget constraints, and they are key for scaling up or replicating effective programmes and interventions. A major challenge for all programming in

Table 2 Do's and Don'ts in mental health interventions in complex emergencies

Do's	Don'ts
Advocate for using emergency funds to lay foundations for more sustainable development programmes	Do not start short term services without having plans for the post emergency period
Connect mental health projects to existing policy frameworks, such as national (mental) health policies and plans	Do not expect that the existence of mental health policies and strategies will automatically lead to increased commitment and funding by the government
Advocate for establishing or strengthening mental health policy frameworks	Do not wait for others to lobby
Ensure support from local, regional and national (health) authorities	Do not work on initiating programmes without signed agreements of the authorities
Actively promote coordination between different stakeholders (local organisations, INGOs, government)	Do not wait for others to set the parameters or first steps in coordination
Promote information sharing and equal participation of all agencies	Do not be afraid to cooperate
Promote interagency cooperation by encouraging parallel planning periods, joint assessments and pooled funding requests	Do not be naïve: sometimes there can be negative interagency dynamics and competition
Cooperate with local stakeholders such as local NGOs	Do not ignore that local stakeholders will have their own agendas
Promote local ownership and leadership in needs assessment, project design, implementation, monitoring and evaluation	Do not expect that local stakeholders can immediately take over activities without support
Ensure contextual relevance of the interventions by giving local stakeholders a real say in the kind of interventions that are developed	Do not only 'check' cultural relevance by superficial measures that simplify local ideas
Make participatory assessment broad and relevant by 1) focus group discussion with stakeholders on perceived needs and capacities, 2) participant observation of real patient/personnel encounters, 3) including assessment of the home situation, functional impairment and support systems of people with mental health problems	Do not base interventions on pre-formulated needs described by external 'experts'
Tailor interventions to available data on age distribution and prevalence figures of mental disorders and psychosocial problems	Do not use a 'one size fits all approach'
Integrate mental health into non-specialised health care and refer only those cases that need more specialised treatment	Avoid separate programmes for trauma or grief at PHC level
Use a community perspective of mental health problems	Do not isolate mental disorders from the context in which they occur
Ensure that mental health care includes psychosocial concepts and practices	Do not promote the medicalisation of mental health problems
Build capacity within existing public health systems	Do not drain resources from the public health systems in order to employ them in NGO projects
To strengthen/remodel existing structures (public or traditionally, community based structures) is usually better accepted and more sustainable than introducing completely new strategies	Do not create parallel networks that compete with the general health care system
Work towards an integration of mental health care on all levels (community, primary health care, secondary care)	Do not focus on only one level of the system
Install referral systems between community, primary care and secondary care services	Do not leave workers on the primary care level overburdened with cases they cannot handle
Consider using community based psychosocial workers or community volunteers	Do not consider unpaid volunteers as the base of a mental health care system
Use participatory training methods that build on existing experiences	

Do's	Don'ts
Use broad capacity building strategies that cover knowledge, attitude and practice of trainees, and are connected to a planned supervision and follow up	Do not offer training without follow up of results, or supervision of practice
Invest in capacity building that includes training and system building	Avoid focusing on training alone, if the outcome of the training requires changes in the system
Use case detection based on identification in the community	Do not use case detection without ensuring access to treatment, including availability of essential psychiatric drugs and other forms of aid
Create awareness about mental health problems in the community	Do not underestimate the stigma and prejudices associated with mental health problems that may prevent people from seeking help
Reinforce traditional ways of mutual and self-help, and rebuilding the social fabric	Be aware of subtly ignoring or destroying traditional ways of mutual support through top-down psycho education and awareness raising
Integrate monitoring and evaluation from beginning	Do not wait to start planning for evaluation until the end of the project

post conflict or post emergency settings is analysing not only user satisfaction and process indicators, but also measures of outcome and impact (Baingana, Bannon, & Thomas, 2005; Perez Sales, 2005).

One major challenge for many of the programmes described herein has been that donors tend to use short term funding for immediate alleviation of emergency induced needs, without allowing the setting up of programmes with a longer term perspective. This is one of the reasons that the organizations such as the International Federation of Red Cross and Crescent Societies advocate for structural reallocation of humanitarian funds towards risk reduction, and community level development (IFRC, 2009). Development should not be separated from humanitarian need. Rigid separation between emergency funding and development funding makes it difficult to design sustainable programmes. The editors have collected several experiences within this volume. Other contributions did not arrive on time, or exceeded the publishing capacity and will be included in future issues of this journal. We have also tried to summarise the main findings

and conclusions of each of the programmes presented, and tried to extract key factors and recommendations to transform humanitarian emergencies into opportunities in the psychosocial field. Years after an emergency, humanitarian agencies are often confronted with the final destination of emergency funds. Appeals to the public and donors raise considerable amounts of money (Sri Lanka, Haiti). This should not be wasted on expensive short term programmes that sometimes cost much more in logistics than what it actually delivers to the population, or in well intentioned experiments which repeat errors that have already been well documented and are widely known. Emergencies can be unique opportunities to rethink existing models and to introduce changes and new developments in the provision of mental health and psychosocial support in communities. The editors and authors of this *Intervention Special Issue* hope we have managed to provide useful insights in this direction.

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Building up mental health services from scratch: experiences from East Sri Lanka

Mahesan Ganesan

The author describes his experiences as a psychiatrist in East Sri Lanka where he was involved in building mental health and psychosocial services in the context of war and disaster. He stresses the necessity of creating patient and family friendly services, and advocates for the principle of distributing basic services over the whole region, instead of providing a highly specialised service that most of the people who need help cannot reach. He discusses the importance of empowering both staff members and patients, and emphasises the important of valuing common sense solutions and approaches to the problems faced by service users.

Keywords: common sense, conflict, mental health, patient and family friendly services, Sri Lanka, tsunami

Starting from scratch

I started my work as psychiatrist in an old fashioned psychiatric hospital in the capital, Colombo. It was a horrible place, with 2000 patients, many of whom were admitted for long periods. My ward was overcrowded; for 100 patients, we only had 30 beds. The rest slept on the floor. It was a patient unfriendly place, where all in-patients were locked up, and people were sometimes beaten by staff. The sanitary conditions were appalling; there were no private bathrooms, and people had to wait undressed in queues to get to the few showers available. I wanted to leave there as soon as I could, because I was afraid of getting used to seeing people

with mental disorders in such dire conditions. I was afraid I would start considering this normal or acceptable. Therefore, I decided to go to a place where there was no psychiatric hospital and no psychiatrist.

In 1999, I started to work for the government health services in Batticaloa, in the Eastern Province of Sri Lanka. The district has a population of almost half a million. It has also been severely affected by the civil war that raged in Sri Lanka between 1983 and 2009. Since 1980, there had not been a psychiatrist in the district. However, between 1978 and 1980, there was one psychiatrist, but all that remained of his presence was a monthly outpatient clinic for the prescription of medication, and the possibility for psychiatric patients occasionally being admitted to the general hospital. The government had not allocated any funds for the development of mental health services in the district.

A patient friendly service

My first concern was to start a patient and family friendly service. I wanted the staff to be kind and put energy in the relationship with the patients and their relatives. I believe that if you invest in being friendly, your patients get better more quickly. If the experience in the hospital is a pleasant one, the person will more easily come back in the future, in case of a relapse. In fact, when the staff is kind, the patients are much more

like to stay as long as they need care, instead of checking out before they have improved sufficiently. Additionally, if people feel they are treated like human beings, they will be much more likely to refer others, or bring along others from their community who are suffering from mental health problems. We never forced people to stay with us for treatment; but when we felt they were not yet ready, we would try to convince them to stay and negotiate a little, *'why the hurry, just stay another day'*. However, we left them in control of their own decisions.

I also stimulated my staff to maintain friendly relations with the traditional healers. We always allowed patients to go to the healers if they wanted to, making sure that they still would feel welcome to come to us. The healers heard of this, of course, and actually started to refer some of their patients to us, telling them that their problems were mental rather than supernatural. In this way, we built up a degree of cooperation with them.

In the hospital, our patients were allowed move freely, going anywhere they chose. We locked away the drugs, but there were no *'staff-only'* areas. We encouraged family members to visit and welcomed them the whole day. Families benefited from meeting other families and learned that they were not the only ones with a person with mental illness in the family. Also, they could advise one another. They can observe how staff members react to their family member, and see that they did not argue about any delusional ideas they may have had, but behaved in a respectful way.

Patients are often hospitalised after a violent incident, such as when they have broken furniture or threatened those around them. If a patient is released, and the family has not seen him since the incident, they often still have that picture in mind. If they see

the patient regularly as he recovers, they will see how the patient is gradually changes. As a result, they will feel more inclined to take him home and make a new start. In contexts where this doesn't happen, there is a real problem with families refusing to accept responsibility to care for those that have recovered.

Responses to disaster

In 2004, the Batticaloa district was stuck hard by the tsunami. Over 2,800 people lost their lives and nearly 60,000 people lost their homes. Many more lost their livelihoods. Much of the infrastructure of the densely populated coastal areas was affected. In this post tsunami period, many aid organisations and groups came to offer assistance. Some came without any prior communication, or invitation. They were trying to help, but many well intentioned actions were not thought through and had serious, negative consequences, as I have discussed elsewhere more in depth (Ganesan, 2006). To me, it was disappointing, and sometimes shocking to witness how organisations brought a very medical model in response to the psychosocial needs of the survivors. Moreover, it seems that often the programmes were predesigned somewhere else, without any consideration of local culture or structures in place to help the survivors in this particular context. Many organisations planned short term interventions, sometimes without checking whether there was any effectiveness of their inventions. The few organisations that stayed for a longer period, often had frequent rotations of key staff, so that it was difficult for the recipient community to have a meaningful relationship with these organisations. They often communicated with the people they were counselling through translators. However, these translators were often not trained as translators,

but were nonprofessional staff, such as drivers, and often had a very limited capacity to effectively mediate the sensitive communication that takes place during a counselling session. Despite all the chaos, it was possible for some government, non-governmental and international institutions to create innovative responses for coordination, and for services to vulnerable groups.

Serious psychiatric disorders as the main priority during war

I always kept severe mental disorders as my priority. That required some persistence, particularly during the war and during the post tsunami period when many institutions wanted me to focus on ‘*trauma victims*’ and people with posttraumatic stress disorder. I decided to focus on the serious psychiatric disorders for the simple reason, no one else was. Psychiatric illnesses cause real problems within a community, and there were many other service providers who provided community based support to the survivors of violence. It did not seem strategic to use the small mental health team to engage in direct work with a vast population that had a range of complex problems related to conflict. We would be swamped, and make little difference.

It was also a matter of equity, as people with severe mental disorders were among the most disadvantaged people. Although in Sri Lanka the health service is free, it is not really easily accessible to the very poor, because of hidden costs like travel and loss of income when one is visiting a hospital. Improving mental health means reaching out to these people. So we started to organise out-patient clinics in other towns in the region. The first was in Kalmunai (in a neighbouring district with no psychiatrist), where we began with eight registered patients, only once a month. Now there are

18 bi-weekly clinics, with over 3,000 registered patients. The manpower came from the local hospitals, the directors allowed us to use the services of their staff. They needed some training, but basically we selected those who we thought had a friendly attitude towards patients and the right sort of humanistic values.

I also found people in the local communities who were willing to help us as volunteers, and also school teachers who had training through the education department. They were released for three days per week to counsel children and their families. The Kalmunai monthly clinic has now become a mental health unit, and with some private donors we have been able to construct a new building in the backyard of the hospital. Since 1999, I have been able to help develop six mental health units in conflict affected districts, all in the compounds of an existing government general hospital, where people felt at ease to visit.

Egalitarian leadership

I did not make rounds. In hospitals, there is a tradition of the doctor making rounds, talking about the patient in difficult words that the patient cannot understand. Instead, I spoke with the patients and my staff in an informal way, like chatting in the morning when we feed the fish in the pond in our compound, or when walking around on my own. I did not tell the nurses what to do, since they knew the patients best, however, I did try to stimulate them to use their common sense. Of course, a nurse could ask my advice when he or she had encountered difficulties. A nurse could also ask me to talk to a client to check the diagnosis, and I signed the prescriptions.

This approach requires training staff members, but not through lecturing. The knowledge base of psychiatry is not very

impressive anyway. I prefer using roleplay of real situations, and challenge the participants to use their common sense. That was my biggest job, to make people use their common sense, and to relate to patients more in the way that they would approach their friends and relatives.

With the mental health team of medical officers, nurses and social workers, I also realised that a part of my job was simply to give them space to work, without fear of punishment. Operating in a hierarchical, and often harsh institutional environment, I saw that if I gave *'my staff'* support to use their own common sense, stimulate reflection on their efforts and stood up for them when they came up against institutional barriers, they were able to work wonders. As the team blossomed, I found that as the consultant psychiatrist, I became more peripheral to much of the daily work.

Getting involved in the community

My emphasis on severe mental disorders did not keep me from getting involved in other problems within the communities. There is a home in Batticaloa, run by Catholic sisters, that houses children with intellectual disabilities. I started to pay monthly visits. Then it became clear to me that there were many intellectually disabled children staying at home, because the regular schools did not accept them. I found some social workers who made a survey, and then we started day-care centres for these kids. There are now 18 centres in the area, providing services to over 500 children and their families. There is also now a child guidance clinic with a multidisciplinary team at the general hospital. The people of the Eastern Province now have easier access to these services than people in the capital.

In a similar way, the mental health unit of Batticaloa became involved in child protection. First started case conferences with personnel from the legal system and non-governmental carers. One of the aims was to make the legal people more aware of the needs and welfare of children. They were used to seeing children as witnesses of a crime, not as victims that needed care and emotional support. The legal process around child abuse basically is unfriendly to children, often a retraumatizing process, and we wanted to change this. We therefore started a transit home that could work as a temporary safe place for abused children.

In a similar way, we got involved in gender based violence (GBV) by organising a task-force that included both government staff and nongovernmental workers. We trained all 700 staff members of the Batticaloa hospital (including doctors and nurses, but also non medical staff, including the cleaners) to recognise signs of gender based violence. We then opened a GBV desk at the hospital where victims could be referred. The workers have good connections with the police, safe houses, community workers and all kinds of nongovernmental organisations. That started in 2005, and now we now have such desks in six hospitals in the conflict affected districts.

Skills

I was not educated to build mental health and psychosocial services, as it was not part of my medical training. It helped that I have a sceptical approach to what the pharmaceutical industry tell us to do, and to what we read in books. Furthermore, I trust my common sense.

For the job, I needed to develop my networking skills. Part of that is supporting the people who are willing to help you when they are facing challenges. I made my networks

in the communities, and did not rely so much on psychiatrists.

Another important skill I had to develop was giving interactive training, i.e the skill of helping people to explore the skills they already have, making them more aware of these skills, naming these skills, and at some point also challenging their skills so that they can reflect on them and improve them. At some point, I needed funding for the initiatives I was developing. That required the skill of thinking in terms of projects and writing project proposals. Again this is not something that I picked up in medical school. Perhaps the most important skill is

being able to learn from your experience, including learning from your mistakes.

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The dispossessed: diary of a psychiatrist at the Chad/Sudan border (2004)

Lynne Jones

While working for an international humanitarian organisation in the Sudanese refugee camps at the Chad border, British child psychiatrist Lynne Jones kept a personal diary. In this diary, she reflects on the practical challenges and moral dilemmas facing a mental health practitioner working in this difficult context.

Keywords: Chad, ethics, mental health care, people with severe mental disorders, Sudanese refugees

(In order to protect confidentiality, personal details of agencies, colleagues and patients have been altered.)

Guereda, Chad, Friday 9 July 2004

The man from 'Help the World' told me this was the *most inhospitable landscape* he had ever experienced, and he was glad he was on his way out. He had done his bit, set up his programme. He was getting married next week, and nothing would induce him to stay. Yet, I have to say I like it. An irregular plane of scrub and thorn stretched beneath a vast sky, the horizon broken by small isolated treeless mountains of earth and rock, giving the feeling that a giant mole has burrowed through the terrain. There has been no rain for a few days, but a gloss of green covers everything. There is the sweetest smell in the air when we stop to take a break, and birds everywhere: small finch like ones, ibis, egrets, herons and storks, bright blue birds

with trailing tails, swallows, swifts, turtle and collar doves, all hinting of the water to come.

The only other traffic on the track is an occasional land cruiser, all with aid worker IDs, all of us alien forms in another world. The pictures outside my window are archetypal, from the human geography textbooks of my childhood. This is the 'Savannah'. Here is a white turbaned man riding a camel. There are more camels, quantities of them munching at new foliage. Here are the children, tending goats and riding donkeys. There are villages of round thatched huts, near which women till tiny patches of earth, back breaking work in the boiling sun. Here are yet more donkeys and camels and goats, seemingly quite untended, until suddenly a solitary man, woman or child emerges out of nowhere at the side of the road, and takes ownership.

In the beginning, all the wadis we cross are dry, but by early afternoon the clouds gather in front of us. First the dust comes creating a brown haze around the car and then abruptly, pounding rain. The water is not absorbed. It simply sits on the surface so that the whole landscape suddenly acquires a patina of silver, taking on the wintry feel of a Breughel picture, minus ice skaters. The rain stops and the wadis still seem passable. Within half an hour, the water has drained away leaving more astonishing green, and even more birds.

Sunday 11 July, Mille Camp

The camp is made up of rows of United Nations High Commissioner for Refugees (UNHCR) tents, one per family. In many cases, the tent has already been absorbed into a complex structure of mud walls, providing cooking enclosures, large oven, and surrounding outer walls. Sometimes a thorn fence and cloth roof provides additional space. Inside the tents, families have put down mats and carpets. I am constantly amazed at the capacity to construct homes out of nothing, in the middle of nowhere.

The organised camp is surrounded by fields full of people. Vividly dressed families have erected tiny make shift shelters in the dust, from a couple of branches and a piece of cloth or plastic. These are the *'spontaneous arrivals'*, refugees who walked here of their own accord, as opposed to the ones convoyed from the border area in UNHCR trucks. According to more cynical aid workers, they could be refugees trying to register twice to get more food and supplies, or perhaps, horror of horrors, they are local citizens from Chad who see things being handed out to refugees from Darfur and not surprisingly want a share for themselves, this being one of the poorest places on earth.

Today I have a meeting with 10 of the Faquirs: the local religious healers who all want to discuss what they can and cannot treat. Regarding mental illness, I am becoming convinced that all societies have a category for the really disturbed, and that the broad parameters of what falls into it are the same in most places: the violent, uncontrolled, bizarrely behaving, person who can no longer take care of themselves is called *majnoon* and his problems are caused by *Djinn*, devils. The illness is treated, as in many Muslim societies, with the word of God, written upon a board and the ink washed into a drink to be taken by the

patient. However, the Faquirs make some subtle distinctions, there is another form of *majnoon*, called *amfitfit*, where the man falls to the ground unconscious with lots of saliva. He fights or waves his arms, and then he recovers. *'This you can try to treat 99 times with prayer but it does not get better'*, one Faquir tells me.

But none of them can work here.

'Can a man go the forest without an axe and still cut down a tree', one asks me. All of them abandoned their books and boards and incense, and all the tools of their trades, when they fled. They are strangers here and guests, it is not necessarily right to work, which means there is no mental health care of any description in the camp.

We talk on. I explain my own view of *amfitfit*, which sounds like epilepsy. They are very interested. I ask if they would like to learn more. We could teach them our understandings, they could teach us theirs. They think this an excellent idea. One by one they stand and thank me with great formality for coming and meeting them, and wishing to help. They are all elderly men. Most have lost at least one or two family members, along with all their possessions. One man is now sole carer of 12 grandchildren, his two sons, and their fathers, having died. Their long white robes and turbans are not very clean, their faces are lined, their feet calloused and dirty. Some hold small strings of beads. One has severe cataracts. I am a strangely dressed white woman behaving in a very unwomanly fashion, yet they treat me with extraordinary kindness and courtesy, as an honoured guest and colleague.

Then one of the Faquirs says he wants me to see a patient. We walk to the outskirts of the camp where a thin naked man is chained to a tree in a small enclosure of thorns, the kind normally used to keep cattle in or out. When we get close he curses us, refusing to answer

our questions, telling us to *get away*?. He has been there 30 days. I get all the water we have in the car and give it to him. He gulps down two bottles but keeps up his angry muttering. We go and find his brothers, camped almost a mile away in a homemade shelter of plastic on poles, stretched over two or three carpets. They explain that Abdul has been violent, aggressive and paranoid since his early twenties. He is now 34 and was calmer in the last few years. When the war began he went back to his old thinking and preoccupations, and started fighting and threatening people. When they had to flee Darfur he refused to go, so they bound him and brought him with them. They have no alternative to chaining him up. The camp management says *'no tents for individuals'*, but they cannot live with him when he is like this. So he is getting worse by the day. Not surprising given his exposure to the wind and sand and heat and rain.

It is quite unbearable. I cannot unchain him in his current state. Chad has one psychiatrist who has six beds in the capital city, some thousands of kilometres away. I tell the family I will see the camp management about shelter and we will start treatment here, with the anti-psychotic medication I have brought with me from England. On the way home my driver Hassan says, *'Dr. Lynne you drag George and me through the desert and back and then you give all our water to a madman.'*

'I know, I know, I am so sorry, but we have more water at home and he has none.'

'Never mind', Hassan is smiling. He puts on Sudanese music that he sings along to while George translates; it is about a man mad for love that wants the Faquir to cure him.

Tuesday 13 July, Am Nabak camp

Khadije is 13. When the army arrived at her village, her mother was in the house with

her two newest twin babies, boiling water in a pot. The soldiers burst in and took the babies and threw them in the boiling water, then they cut Khadije's mother's throat. Khadije, tall and stunningly beautiful in her pink wrapper, smiles and smiles at me when I am introduced, then she runs behind one of the thorn enclosure walls and hides her head to cry. When I follow her, she does not want me to see her tears. Then more women come to sit with us, her grandmother, another woman whose 10 year-old son was captured and killed while tending cattle, and a third, whose daughter was beheaded. This latter woman cannot speak. She mumbles, cries and wanders, making the same gesture over and over with her hands, turning them out, palms up as if to say, *'can you believe it?'* The community thought of tying her up, but worry that it will make her worse. She is not dangerous, more like a female Lear, mad with grief at the loss of her daughter. We sit behind the thorn hedge while each woman tells her tale. *'Tell'* is not the right word. They use few words, and many hand gestures, yet Asra translates full sentences, so I am not sure what comes from her memory of previous telling, and what is being said now. But it does not matter, as the women seem to want to be here. I realise that in these meetings my main function is as a witness. I am the outsider to whom no bad thing has happened, my heart is not burdened, and so I can listen.

There are no tents or earth walls here in Am Nabak. Three communities have made their own encampment in the back of beyond, and everyone has constructed tightly woven briar fences, usually around a single tree. The slightly better off have roofed these with mats, or cotton, or whatever they can find. Water is now trucked in from a town an hour away, and one of the water agencies is checking to see if wells can be made. If so, it will

become an official camp. Meanwhile people struggle on ‘unofficially’ in the dust.

It grows cooler. Asra marches me around, her wrapper blowing in the wind: Here is a ‘boy who has not talked since the bombs fell, do I think he is mad?’ Sadly I do not. The story of seven days lying unconscious, bleeding from both ears and a swollen head suggests brain injury, more than psychological damage, as do the limb contractions. When the inevitable dust storm blows up, preceding a heavy downpour, a whole crowd gathers, pulling out sheets and mats to find a way to shelter me while I examine the child. I am given glass, after glass, of sweet tea. I feel completely helpless in the face of these kinds of problems. At present, we have nowhere to refer or investigate, and the families are so gracious and grateful for nothing at all. It is a strange reversal from home, where psychological diagnoses are seen as the last resort when physical explanations fail. These people seem to seek out the psychological, regarding it as something that can be undone by either the Faquir or me. In a world with no access to modern health care, physical complaints are far more damning.

Wednesday 14 July, Kounoungu

In grade 8, at the school in Kounoungu camp, there are 15 children and young people between 13 and 26 years of age, every single one of whom has lost a first-degree relative or more, mostly by Sudanese army bombing. The stories are heartbreaking. *‘My five-year-old brother could not run fast enough, and so fell behind and he was killed.’ ‘My elder brother stayed in the house to help my grandmother, and was there when it caught fire.’*

Every child and every family I talk to has had similar experiences. First bombing from the air, then the army arrived with guns mounted on cars. They surrounded the villages on three sides, and then moved in

leaving one way out. Sometimes armed Arab men accompanied the army on horseback. Often the planes pursued the lines of those fleeing and continued to fire on them, so the young, the old and the less fit got caught. After they fled, the villages were systematically and thoroughly burned, leaving nothing to return to. Even the pots had holes shot through them, not random damage, but a single shot through each one. The women all pull out pots they managed to retrieve to show me. Each has a ragged hole shot through the base. *‘They want us to starve’*, one says.

Saturday 17 July, Am Nabak

We live in a compound with three rows of single mud brick rooms around a beaten earth square. In the day it is blindingly hot. My favourite place is on the top of some ruined old barracks type building. It has a sign outside celebrating the *glorious martyrs* in French, although there is no indication as to the cause for which they were martyred. Up on the roof I am on the same level as a tree full of nesting storks and their young. I can sit and look out over mud walled compounds and deserted streets to the full wadi and the dark green of the mangrove trees.

Workdays have acquired a kind of rhythm. I wake around five thirty with the light, and am up by six thirty, sitting in the shade of the office wall, drinking tea, eating the small balls of cooked dough that make up breakfast, and watching the water man fill the plastic water barrel from the water sacks carried in on his donkey. Then we drive out to one of the camp clinics, with Hassan singing along to his cassette player, and George sounding off on whatever he has just heard on the BBC about Darfur. He is optimistic. He feels the world is finally paying attention and that now things will surely ‘happen’. I do not share my own Balkan and Iraq tinged

pessimism with him. He blames everything on the Bashir regime. He tells me there is absolutely no distinguishable difference between himself and his Arab neighbour, and in the eighties, Africans and Arabs all got along well. This government has used ethnicity deliberately to create conflict. George says he can remember the British in Sudan from his childhood and wishes we had not gone. There was a Mr. Moore he liked very much. His English, learnt from school, listening to the World Service and reading *The Economist* when he can get it, is almost perfect.

We spend some hours at one of the camp primary health care clinics, with me seeing anyone people choose to bring, and then we drive home before dark. In the evenings, I can usually have a shower by pouring donkey-carried-water over myself with a jug. The egret roost in our compound is now full of adolescent egrets, who never stop jumping about and sort of moaning, probably complaining about having to go to bed early. They look like egret punk rockers with little yellow tufts on their heads.

This afternoon I see one paralysed girl and two children scared out of their wits by the bombing. This phrase actually has some meaning here. One boy has been in a vacant trance like state for months, since the bombing. He has no physical injuries. There is a girl who sees the devil as a ball of light that picks her up off the ground and throws her down again. After these, and four cases of *amfitfit*, I am really ready to go, but then some women come running, they have found Tabitha and I have to see her. Half the camp is concerned about Tabitha, because she leaves her baby under a tree in the hot sun, wanders off and won't feed it. Every time we look for her, she is gone. This time, someone brings her in and she sits down voluntarily on the carpet in our enclosure, a rake

thin woman, with a skeletal face and staring frightened eyes, plucking anxiously at her clothes.

She has her baby with her, tied tightly to her back. She unties him for me to look. He is a tiny old man in a bundle of rags: enormous eyes, tiny limbs, skull like head, sunken chest and large distended abdomen, breathing rapidly, hot skin. When I touch his eyelashes, they scarcely move. He whimpers a little. I ask Tabitha to feed him and she puts his mouth to a flaccid looking breast, which he initially sucks. But after a few seconds his head falls away, mouth open, uninterested in the proffered nipple. Tabitha does nothing to encourage him. She is not sure where she is, or what she has been doing. She knows this is her baby and tells me he is 10 months old. She thinks she has three others, she cannot remember their ages. She cannot explain why she keeps running away. *'Will you and your baby come with us to the therapeutic feeding centre we have in town so we that can feed you both,'* I ask. *'You will have a shelter in our feeding tent, and be much more comfortable than here.'* She looks uncertain, *'what about my sons? I need someone to watch them.'* *'Get in, let's find someone.'* In a moment we are all in the vehicle driving to her section of the camp.

When we arrive people crowd round. When we ask if anyone can help us by caring for Tabitha's two older boys for two nights, everyone backs away. Then a thin angry looking man appears in a long blue shirt. *'I am her brother. She is forbidden to go, absolutely not.'* Tabitha looks at him, listens to his rapid angry instructions and gets out of the car, hiding herself in the middle of the crowd, baby held indifferently in her arms. George and I try to explain, *'the baby is very sick, it is just for a couple of nights, if he stays here he will die.'* *'If that is Allah's will',* says the angry brother. *'I cannot believe you mean that.'*⁹ I pull him over to the child and pull back the clothes to show

the protruding ribs and swollen stomach. *'We can change this. Would your father want his grandson to die when he could be saved?'* The man sets his lips, looking stubborn and saying nothing. *'Maybe its jealousy.'* George mutters to me, *'I don't believe he wants the boy to do well. She will run away. She won't take care, she's crazy. I don't think so. I think she's hungry and feverish, but why not come with us and help, and I will take responsibility for her not running away.'*

I am near to tears, exhausted with the day, worried about the darkness, dust and rain that I can see quite literally marching towards us across the desert. No way will we be home before dark now, and Dr. Jim, our medical coordinator, has already warned me about security on the road.

George starts talking to the crowd. I no longer ask for translation, he can do a much better job negotiating if given a free hand. He stands very still and upright, talking in the serious, solemn manner of the schoolteacher that he is. His white hair (come much too soon for his own liking) adding to his gravitas. People listen.

Apparently George was making a speech about the foolishness of his people (and he included himself). How they were too suspicious and unable to accept the generosity of others? Here was the world on the doorstep wanting to help, and the kind lady doctor who had come all this way, and had no reason to be here except that she cared about sick people? Look now; she was crying because a baby would die, and why did they turn down this offer of help, they were lucky to have such a chance? I was quite moved myself when he related all this to me later, but while he was speaking I did not feel either kind or generous, just completely pissed off and exhausted.

'I have had it George', I say after what seems like 15 minutes with no change, 'get in the

car we have to go. We will be desperately late as it is.'

I cut through the now enormous crowd, to the vehicle. I am also worried that the protracted argument over the child will actually exacerbate a family conflict. I will have to let it go. What, after all, is one more dead baby? Except that I know this baby, and that makes him my responsibility. We are in the car. The brother comes running. Somehow seeing us leave has precipitated a change. He will come with one more child and Tabitha and the baby, his wife will watch the other boy. We wait another 15 minutes while he gets his carpet and puts on his turban, and we are on the road, driving an hour through darkness and pouring rain, back to Guereda to get Benjamin (our nutritionist) to admit them to the therapeutic feeding centre. *'I know this mother!'* Benjamin says when he opens the car door; *'I have been trying to get her in for days.'*

Monday 19 July, Mille Camp

A man came to the clinic yesterday and asked me to visit his 'crazy' niece. He took me outside the camp, to a small, circular, mud brick animal enclosure built to waist height with a piece of UNHCR tarpaulin stretched over it to make a roof. *'Her name is Amela',* he said, *'she is in there'.* I got down on hands and knees, and crawled inside. Sitting against the back wall, just visible in the dim light from the entrance, was a skinny, completely terrified, teenage girl. Her longish hair was clumped into uncombed tufts, she was wearing a filthy ragged dress, and all visible skin was covered in a crust of dirt. She sat on a woollen blanket that smelled of pee. The only other things inside were a couple of filthy tin plates with food remains, and some rags. When the girl saw George crawling in after me, she started screaming

'they are coming to kill me, they are coming to kill me', and wriggled rapidly out of the shelter. Immediately, her uncle started kicking her hard and shouting at her. By now I was back outside myself, the girl had just escaped her uncle's grasp and was crawling away again, across the white sand between stunted trees, her uncle pursuing her. So I ran between them, placed my arms firmly around her from the back, held her still and helped her sit up, shouting at her uncle to please leave her alone, with George rapidly translating. Then I just held her, rocking her, saying repeatedly and quietly *'it's alright, it's alright'*. Within a minute she had turned and wrapped herself tightly around me clinging, with her head buried in my shoulder. Some situations do transcend language. George appeared to be admonishing her uncle about his behaviour, so I left him to it and crawled back inside the hovel. Amela followed me quite docilely, and then lie down and put her head in my lap. After she had calmed down, I went out to try and explain that there was no way to assess if she was actually psychotic, while she lived like this. She was obviously terrified and miserable. Living in a hovel like an animal, and being beaten if she tried to go out, would not contribute to her mental wellbeing.

Today I take Beverly, one of the UNHCR protection officers, to see Amela. I also take Diana. She is an Australian missionary who has lived in Guereda for 15 years, runs a small clinic, gives classes, grows and sells trees, acts as a de facto social worker and knows everyone. She thinks she might be able to help find a local foster family. Hassan somehow knows at which tree in the middle of nowhere he should turn off. Amela is still in her hovel. On this occasion she talks, she is not happy, she is scared. Her uncle beats her, she does not sleep, and she is hungry. Beverly looks at the hovel and agrees they

have to find another solution. Meanwhile Diana has brought soap, water, and fresh clothes, and says she will spend some hours with Amela, giving her a wash and getting to know her. So I head off to the camp clinic.

Abdul, my psychotic man, is definitely better. After I jumped up and down for two days and became a complete pain, UNHCR gave his family some plastic sheeting, but no poles. More jumping up and down, actually this time I switched to wheedling in the *'Help the Homeless'* tent, and the man there promised he would ask *'People who Care'* for poles. If you want to know why UNHCR and *Help the Homeless*, who are the camp managers, have responsibility for one bit of shelter building material, and *'People Who Care'* (who are never there) have the responsibility for another, you will have to ask someone else. I am just happy Abdul has a roof! An unsteady affair, which will have given little protection from yesterday's storm, but is better than nothing. At least it is located close to his family.

Today he greets me! He takes my hand and allows me to take his blood pressure. He is dressed, talking with his family, no longer cursing, and reasonably coherent. He is still unpredictable. I sit down in the clinic tent with the family and Dr. Salim, one of the general practitioners working here, to make a long term plan.

While we are doing this, Diana turns up with a clean, quite transformed Amela in her car. She has brought her to the camp clinic because Amela's temperature is 38.5. Dr. Salim diagnoses malaria. This means taking chloroquine and paracetamol at regular intervals for the next few days, and none of us can see how she will get the tablets if we put her back in her hovel. *I can take her home for a few days, and we can treat her there*, Diana offers, *'it would mean we could see how*

she was mentally as well. Her uncle was happy for me to take her. 'Do it,' I say, 'we cannot leave her sick in that place. I will find UNHCR and inform them, and I will take responsibility.'

I get back to Guereda in mid afternoon, having searched the camp in vain for Beverly. I visit Tabitha at the feeding centre. Both she and her baby are unrecognisable. Food has transformed the baby in the way water changes a wilting flower, his skin is smooth not wrinkled, his tummy no longer swollen, and he holds up his head and gurgles and smiles and responds to his mother's kisses. She has lost her anxious bewildered look, shows no signs of confusion, and now behaves like any other mother. And, the other mothers, instead of avoiding her, now chat and talk with her as normal. I wonder if the abandonment was because she believed that the baby would die. Tabitha's brother is delighted. *'I've been telling her for weeks she should come here,'* he tells Benjamin. This is the first time I have treated a mental disorder with food.

Meanwhile various reports are coming in suggesting there are just as high levels of malnutrition in the local Chad population, as among the refugees. In the evening I go round to Diana's house to check on Amela. There is a mum with a starving baby who having been turned away from the feeding centre a few months back and has struggled on alone. She only came to Diana today because the baby is almost moribund.

Tuesday

I am now in serious trouble with UNHCR. I tried three times yesterday to find both their protection and field officers in the camp, to tell them I had moved a refugee. I tried again at 7am today, but no joy. Just as I am leaving for camp, Albert, the UNHCR field officer comes storming into our compound demanding to see Dr. Jim, our medical

coordinator, waving his fist at me. Dr. Jim appears and stands quietly while Benjamin translates Albert's tirade against irresponsible doctors who kidnap refugees and transfer them with out permission, and against express instructions to the contrary. When he finishes I ask if he would like an explanation.

'Yes,' he says with little enthusiasm. I apologise and explain that I understand the rules and have no wish to act without his authority, but that yesterday I was faced not simply with a protection problem that could have waited a day or two, but with a very sick girl with a fever who needed medication, which I did not think she would get in her existing living situation. It was a medical decision, just as transferring babies to the feeding centre was. Of course, if he feels it is inappropriate, he can take the girl back to her uncle right away, but I think it extremely unwise and hope UNHCR will take responsibility for her wellbeing.

'I am so sorry,' I repeat again, trying to look abject and going into my *'junior- hospital-doctor- what- an- idiot- I-am and how much I-have-to-learn-from-you'* mode. This is a tried and tested approach that has worked in health systems around the world. I have found it effective in humanitarian hierarchies as well. *'I really tried to find you three times yesterday, and this morning. I do apologise.'* Albert appears very slightly mollified,

'Of course if it is a medical matter, but I must in all cases be informed. You cannot just move refugees around as you wish. As soon as she is well we must make arrangements for her to be fostered in the camp.' *'Of course,'* says Dr. Jim, *'and can I apologise on behalf of the Agency. We have no wish to disrupt procedure.'*

Albert leaves looking askance at me one more time. Don't I understand he is trying

to look after 30,000 refugees? What with demanding single tents for madmen and kidnapping feverish 15 year olds, I think he cannot wait for me to leave. This is the trouble with mental health, it brings up the most difficult to solve cases. All this fuss over just one or two people, neither of whom can be said to be upstanding, productive or attractive members of their communities, neither of whom are actually dying, at least at this moment. But all my life I have simply wanted to be on the side of the most dispossessed. I cannot think of anyone more

dispossessed than a mentally ill refugee. Someone has to speak up on their behalf, and demand the things they cannot demand for themselves.

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