



Conflict Prevention & Reconstruction

Integrating Mental Health and Psychosocial Interventions into World Bank Lending for Conflict-Affected Populations: A Toolkit

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A Toolkit

The World Bank

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Preface

The World Bank recognizes that economic and social stability, and human security are pre-conditions for sustainable development.¹ Violent conflict, within or between countries, results in loss of life and destruction of assets, contributes to social and economic disintegration, and reverses the gains of development, thereby adversely affecting the Bank's core mission of poverty reduction.

Among the many adverse effects of conflict is the impact on the mental and psychosocial wellbeing of large parts of the population in countries and communities affected by conflict. These effects are often referred to as the 'silent wounds' of conflict because they frequently remain hidden, un- or under-reported in post-conflict needs assessments, and consequently un-addressed in most donor-supported post-conflict reconstruction programs.

This Toolkit is based on the premise that failure to address mental health and psychosocial disorders in populations that have experienced mass violence and trauma caused by conflict will impede efforts to enhance social capital, promote human development and reduce poverty. It is also based on a growing body of evidence showing that interventions to address mental health are both desirable and feasible, in order to support post-conflict recovery, the consolidation of peace and reconciliation, and the transition to sustainable development and poverty reduction. A number of studies document the link between mental disorders and psychosocial suffering and dysfunction. This dysfunction persists over time and is linked to decreased productivity, poor nutritional, health and educational outcomes for children of mothers with these problems and inability to participate in and benefit from development and poverty alleviation efforts.² Support for mental health in conflict-affected societies can thus make an important contribution to meeting the Millennium Development Goals.

The Toolkit discusses approaches and offers guidance on integrating mental health and psychosocial interventions into Bank lending and support for countries emerging from violent conflict. The Toolkit is the product of a partnership between the Bank's Health, Nutrition and Population Team in the Human Development Network, and the Conflict Prevention and Reconstruction Unit in the Social Development Department of the Environmentally and Socially Sustainable Network. It is the first mental health Toolkit prepared by the Bank. The Toolkit will be shared across Bank Networks and Regions and will be updated periodically, as the Bank gains greater experience with mental health and psychosocial interventions. Feedback is welcomed electronically at healthpop@worldbank.org and fbaingana@worldbank.org.

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I. INTRODUCTION

1. Mental Health, Conflict and Development

Addressing mental health is gradually being recognized as an important development issue, especially in the case of conflict-affected countries. Although mental health issues have received increased attention in post-conflict settings, there has been a tendency to implicitly assume that the impact of trauma caused by mass violence (i) may be transitory and non-disabling, and (ii) that interventions in the emergency phase are sufficient. However, a small but growing body of research on factors affecting mental health and effective treatment in post-conflict settings casts doubts on both assumptions

The effects of conflict. At the core of every conflict is insecurity, which fractures social ties, breaks up families and communities, and displaces populations. As of end-2003, there were an estimated 38 million uprooted people (13.7 million refugees and 24.5 million internally displaced persons), of which almost 16 million were in Africa (UNHCR 2004). It is estimated that during the 21st century 191 million people lost their lives directly or indirectly due to collective violence, of which 60% were people not engaged in fighting (WHO 2002). Insecurity, violence and displacement cause the breakdown of social services such as health and education. The stateless and displaced are unable to engage in productive activities, and combined with weak or absent social safety nets there is a slide into poverty or dependence on humanitarian assistance. In addition, traumatic experiences directly related to conflict, often involving the loss of family members, participation in or witnessing of violent acts, and conflict-induced physical disabilities, cause further distress and hamper post-conflict reconstruction and development efforts.

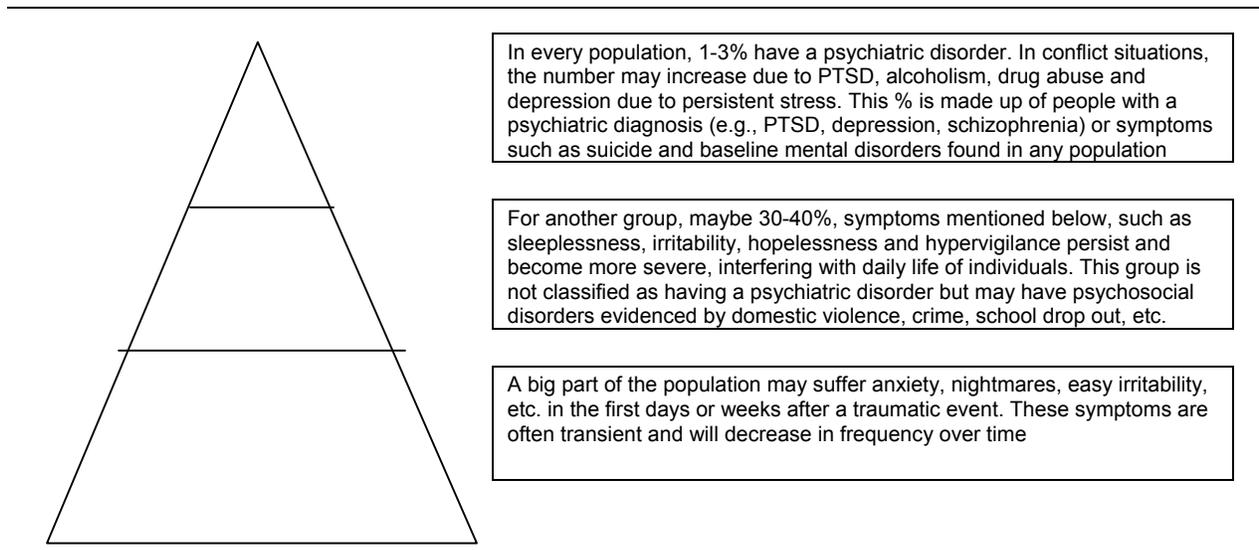
Although conflict is associated with an increase in the prevalence of mental disorders, there are few population-based studies of adults in conflict-affected areas and low-income countries.³ Among refugees, it is estimated that acute clinical depression and post-traumatic stress disorder (PTSD) range between 40 and 70%. Epidemiological studies among internally displaced persons (IDPs) and refugees on the Thai-Cambodian border, in Algeria, Ethiopia, Gaza, and Uganda indicate that 15 to 53% suffer from PTSD as a consequence of conflict. In Uganda, 71% reported major depressive disorder, and in Algeria, Cambodia, Ethiopia, and Gaza, psychopathology prevalence was 17% among non-traumatized against 44% for those who experienced violence. A study of Cambodian refugees by the Harvard Program in Refugee Trauma showed rates of acute depression and PTSD of 68% and 37% respectively (Mollica et al. 1999; Mollica et al. 2001), significantly higher than those found among the general population (10% and 3% respectively). A study of Bosnian refugees in Croatia revealed similarly high rates of depression (14 to 21%) and PTSD (18 to 53%) (Mollica 2001). Recent epidemiological studies of mental health in communities affected by the war in Afghanistan found high prevalence rates of symptoms of depression, anxiety and PTSD (Cardozo et al. 2004, Scholte et al. 2004). Nationwide the prevalence of depression was 67.7%, 72.2% for symptoms of anxiety, and 42.2% for PTSD symptoms. Women had significantly poorer mental health status than men, as did the disabled. Feelings of hatred were high at 84%. Coping mechanisms included religious and spiritual practices; focusing on basic needs, such as higher income, housing and access to food; and seeking medical assistance. Although not every individual will suffer from serious mental illness requiring acute psychiatric care, the vast majority will experience “low-grade but long-lasting problems” (Mollica 2001).

Conflict, social capital and poverty. The link between poverty and conflicts is well established. Nations that have high levels of poverty and that are in economic decline are at greater risk of conflict. When conflict erupts, it creates increasing poverty by undermining the country’s economic, governance and service delivery capacities. Conflict in effect becomes development in reverse (Collier et al. 2003).

Numerous studies document the links between mental disorders, psychosocial suffering and dysfunction. This dysfunction persists over time and is linked to decreased productivity; poor nutritional, health and

educational outcomes; and decreased ability to participate and benefit from development efforts. Studies indicate that populations affected by conflict not only suffer mental health consequences, but also have associated dysfunctions, which can last up to five or more years after conflict. The Bank’s ‘Voices of the Poor’ study also demonstrated a clear link between poverty and mental distress (Narayan et al. 2000).

Diagram 1: Relationship between Mental and Psychosocial Disorders in Post-Conflict Settings



Mental health problems also likely affect the ability of societies to generate positive social capital, which is increasingly recognized as a key element to sustain poverty reduction and human development efforts. Conflict-affected societies face a particular challenge in rebuilding social capital, which is eroded as a result of violence and a breakdown of trust. An inherent attribute of social capital is active community membership and participation for collective action. If due to a mental illness individuals are unable to participate in the activities of a community they will be limited in accessing and contributing to the generation of positive horizontal and vertical social capital. The community too loses, since a high prevalence of mental and psychosocial disorders among its members weakens its ability to form relations of trust, cooperation and mobilization for collective action.

Box 1: Definitions

Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects.

Mental illness is a disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems such as the International Classification of Disorders, 10th Edition (ICD 10) or the American Psychiatric Association’s Diagnostic and Statistical Manual, Revised 4th Edition (DSM IV-R).

Psychosocial disorders relate to the interrelationship of psychological and social problems, which together constitute the disorder. The term psychosocial is used to underscore the close and dynamic connection between the psychological and the social realms of human experience. Psychological aspects are those which affect thoughts, emotions, behavior, memory, learning ability, perceptions and understanding. Social aspects refer to the effects on relationships, traditions, culture and values, family and community, also extending to the economic realm and its effects on status and social networks. The term is also intended to warn against focusing narrowly on mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to wellbeing. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions (PSG 2003).

2. About the Toolkit

The Toolkit provides directions for incorporating mental health and psychosocial interventions into lending and non-lending World Bank support for populations affected by conflict. The Toolkit addresses targeted mental health and psychosocial interventions delivered by specialized mental health professionals, para-professionals as well as a broad range of psychosocial and community workers, aiming to prevent more severe disorders, provide interventions for those who may display early symptoms, and facilitate the early recognition and referral of severe problems.

Who is the Toolkit intended for? The Toolkit is primarily intended for Bank staff working in conflict-affected countries—especially those involved in supporting post-conflict reconstruction efforts—and their in-country counterparts, within government as well as other stakeholders (NGOs and other civil society organizations) that may partner with the Bank in addressing mental health issues. The Toolkit may also benefit international partners, such as UN agencies, bilateral and multilateral donors, working with the Bank to support the transition from conflict to sustainable peace and development.

What the Toolkit attempts to do. The Toolkit aims to: (i) provide guidance for the development of national mental health and psychosocial intervention strategies and programs for populations affected by conflict; (ii) provide guidance for implementation, monitoring, evaluation, and indicators; and (iii) suggest types of interventions targeting special populations, such as orphans and vulnerable children, child soldiers/ex-combatants, physically disabled groups, survivors of sexual violence, and youth.

What the Toolkit does not do. The toolkit does not: (i) address technical issues in-depth, although it includes references where more detailed information can be found; (ii) provide information on management aspects such as financial, procurement, reporting and program supervision activities, which in essence would not differ from other Bank projects; and (iii) address sector-specific issues in health, education or social protection, although it emphasizes that mental health interventions need to be fully integrated and coordinated within and across these key sectors.

3. Potential Benefits

The benefits of interventions to address mental and psychosocial disorder are substantial and may include:

- Empowering affected communities to recognize signs and symptoms of mental and psychosocial distress. These may be at the individual level—such as lack of sleep, feelings of worthlessness and hopelessness, depression, anxiety, suicide ideation, alcoholism—and at the community level—such as increases in inter-personal violence, teenage pregnancies, school drop-outs, disaffected youth, and various manifestations of antisocial behavior.
- Empowering communities to provide support for those suffering from mental and psychosocial disorders due to conflict.
- Helping those with mental and psychosocial disorders to seek care.
- Addressing the inter-sectoral nature of mental and psychosocial interventions, especially through integration into education, health and social protection programs and strategies.
- Strengthening the policy, planning and implementation capacity of national counterparts and partners, including government agencies, NGOs and other civil society (CSOs) or community-based organizations (CBOs) committed to or active in the mental health field.
- Facilitating the coordination of mental and psychosocial interventions between the different national and international stakeholders.

4. Key Principles

Before discussing tools and approaches, it is important to state some key principles that should guide any effort to address mental and psychosocial disorders in conflict-affected societies. Staff should bear in mind these principles in designing and implementing mental health interventions, and ensure that they are understood and followed by counterparts and partners. The principles are elaborated on and referred to throughout the Toolkit.

- Persons with mental disabilities are stigmatized to varying degrees in virtually all societies. Utmost care and sensitivity must be used in all interventions designed to address mental health and psychosocial disorders to avoid stigmatizing beneficiaries.
- In the same vein, interventions must be culturally appropriate and responsive to local social and cultural norms. An intervention that may be acceptable and effective in one setting may be culturally inappropriate in another.
- Given the danger of stigmatization and the need for culturally-appropriate interventions, communities must be consulted and actively participate in designing and implementing interventions. Agencies must avoid imposing pre-determined approaches.
- Adopt a community-based approach that encourages self-help and empowerment, and that builds on local realities, culture and capacities—trust the community you are trying to help.
- Where ethnic cleavages are important and may have played a role in the conflict, great care and sensitivity to ethnic composition must be exercised in the selection of local partners and staff that will be working in target communities.
- Those providing psychosocial support (e.g., teachers, paramedical staff, councilors, community workers) may themselves have been affected by trauma and psychosocial stress. Screening may be required and, where appropriate, treatment before they can help others.
- Be very cautious in supporting research or data collection on mental trauma among war-affected populations. In-depth clinical interviews designed to awake the memories and feelings associated with traumatic events risk tearing down people’s defenses (especially children) and leaving them in a more distressed state than before the interview.
- Above all, do no harm. No intervention is preferable to a badly-designed intervention.
- Bear in mind that psychosocial wellbeing and ability to generate income and satisfy basic needs are inter-related. The ability to gain employment or earn a reasonable income can go a long way to reducing some of the symptoms of psychosocial distress.

II. PROGRAMING FOR MENTAL HEALTH AND PSYCHOSOCIAL DISORDERS: FIRST STEPS

1. Targeting

Although up to 80% of conflict-affected populations may be affected by mental health and psychosocial disorders, the scope and coverage of interventions will invariably be limited by resource and capacity constraints, as well as the fact that in most instances donors and governments do not assign high priority to mental and psychosocial issues in the early stages of post-conflict reconstruction programs. Targeting thus becomes key. The first step before deciding on a targeting approach is to determine the most vulnerable groups, which may include:

- Populations who have been uprooted (IDPs and refugees) and within these, those who have suffered or witnessed violence;
- Survivors of gender-based sexual violence, especially women and minors;
- Survivors of genocide, massacres or violence targeted on civilians and communities;

- Ex-combatants, especially child soldiers and women—the latter often become invisible after conflict,
- Orphans and other children made vulnerable by conflict, such as those in child-headed households, AIDS orphans and street children; and
- Children and adults with physical disabilities caused by conflict, such as amputees and landmine survivors.⁴

With some preliminary information on possible vulnerable groups, there is a need to prioritize interventions. In addition to the overall resources available to fund the Bank-supported intervention, factors to consider include:

- Resources and services available in the communities with priority vulnerable groups;
- Likelihood that the intervention can sustainably mitigate the dysfunction associated with mental and psychosocial disorders;
- The scale of the problem, especially the degree and nature of the traumatic events that have affected the mental and psychosocial health of vulnerable groups, and the way in which this distress impedes socio-economic development such as school attendance, income-generation activities, agricultural recovery, household and community violence, community participation and efforts to improve social cohesion;
- The costs, cost effectiveness and sustainability of the interventions;
- Extent of understanding and receptivity of target communities on the need to address mental and psychosocial problems, which in turn will affect their ability to take ownership for community-based efforts;
- Degree of commitment and/or interest by the government, especially in terms of assigning functional responsibility for mental health issues (e.g., Director of Mental Health in the Ministry of Health) and in supporting the integration of mental health into national health, education and social protection policies and strategies;
- The quality and coverage of basic health and education services, as well as social protection programs; and
- Availability of other stakeholders willing to partner in program development and implementation, which may include central or local government agencies, UN and other international agencies, international and local NGOs, and local CSOs and CBOs.

An important consideration in deciding the approach to targeting is the objective of the planned intervention. If the intervention is part of a nation-wide approach to address mental health and psychosocial disorders, targeting should aim to benefit the largest number of the most vulnerable populations, within the constraints imposed by resource availability, and the capacities of the government and national partners. In this instance the objective is to reach the largest number of affected populations, with cost-effective and easy-to-deliver interventions leading to the greatest long term impact—“getting the biggest bang for the buck”.

If, on the other hand, the aim is to pilot interventions, to demonstrate need and effectiveness as well as to build support within government and other stakeholders, then target groups must be carefully selected to ensure that lessons can be drawn on which to argue the case for a broader effort, and to demonstrate cost effectiveness and the scope for replicability and scaling up of interventions.

The **approach** and purpose of targeting is thus more important than who is targeted. Whether as part of a national program or as a pilot, the approach should build on a situational and/or assessment of needs that involves the community, NGOs and other CSOs, and selected groups of the affected populations (including children and youth). In this process, the entire community and the individuals affected should

participate in identifying those most vulnerable and most in need, as well as those for whom the intervention can be easily delivered and will have the biggest impact.

Targeting may be by **geographical** areas, focusing on those regions most affected by the conflict, working with the populations in those regions to define the factors that determine individual or group vulnerabilities. As experience is gained, interventions can be expanded gradually to other regions depending on needs and resources.

Service mapping can also assist in determining the approach to targeting. In most conflict-affected countries whatever services are still operating tend to be concentrated around urban and peri-urban areas, and when they reach rural areas they tend to be in the most accessible areas or where there is a reasonable level of security for staff to operate. Although access and security in the more remote areas of a post-conflict country may remain a problem for some time, it is important to map areas that are under-served so that they can be targeted for services when conditions improve. Service mapping should also consider the extent to which implementing partners are able to disburse funds in remote or insecure areas, especially where banking facilities are not available. A review of existing practices, especially among humanitarian agencies and NGOs who often operate in the midst of conflict, can help to assess whether, and the extent to which, the ability to move funds may constrain implementation.

2. Special Considerations

In addition to the factors discussed above there are a number of special factors that need to be considered in designing approaches to targeting. These include in- and out-of-school youth, age, gender, avoiding harmful interventions and resource allocation between mental health and psychosocial interventions.

In-school and out-of-school children and youth. Children and youth in schools are relatively easier to target, but following conflict a large number of children and youth are likely to remain outside the education system. As post-conflict countries struggle to rebuild education systems to absorb new entrants, a large number of children and youth who have dropped out of school due to the conflict will remain outside the formal education system. This cohort can be large where education systems have been devastated, and they are more susceptible to alcohol and drug abuse, early sexual activity, and have limited income-earning opportunities.

Although this group is difficult to reach, especially youth, ignoring their needs is dangerous and can threaten the sustainability of peace. Disaffected youth suffering from psychosocial distress generally display anti-social behavior, can channel their frustration into violent activities, and can be easily manipulated and recruited to feed a resurgence of conflict or criminal activity. Annex II summarizes interventions to address children and Annex IV provides a taxonomy applicable to children in conflict-affected environments.

Age may be an important consideration and can involve difficult tradeoffs. In most cases, youth should be a priority because if excluded they pose a threat to social stability. Children too are generally a priority because they are the next generation, on which a more peaceful and socially-cohesive society needs to be built. However, the extent to which adults, especially older citizens, need to be targeted, especially when resources are insufficient, is less clear. Factors to consider may include: parents of young children, who if not assisted may transmit psychosocial stress to the next generation; targeting the most productive young adults when there is a priority on re-activating the local economy; and adults that may face particular problems, such as widows (who are often socially stigmatized and ostracized) and the physically disabled. Targeting may also be influenced by the implementing partners and their area of focus and expertise—UNICEF and Save the Children, for example may concentrate on children and youth. These are difficult

tradeoffs to make, and in the end implementing agencies may need to rely and trust the communities themselves to guide the targeting approach.

The **gender** aspects of the proposed interventions should also be explicitly evaluated. A number of factors need to be considered in engendering mental health interventions, but as a minimum the strategy and approach should be reviewed by a gender specialist, preferably with a good knowledge of local context. Gender aspects to be considered include child soldiers, women ex-combatants, victims of sexually-based gender violence, the special needs and cultural attitudes to widows, and culturally-appropriate ways of treating and seeking the views of women in the community.

While there are well-established international protocols for dealing with child soldiers, there has been little effort to identify gender-differentiated needs. The implicit assumption in programs supporting the reintegration of child soldiers is often that the child soldier is always a boy. Girls are generally not active in combat but play supporting roles in fighting forces, especially irregular armies, and have often been taken as sexual slaves or have been subjected to rape and other forms of abuse. In a number of societies widows are stigmatized and discriminated against (e.g., Indonesia, Nepal), so identifying and addressing their needs for mental health and psychosocial support may require special and targeted efforts. Gender-based focus groups (widows, women) may be used to identify gender-specific needs, especially where women may not express views or needs in front of men, and where admitting to mental or psychosocial stress may lead to stigma and discrimination.

Do no harm—avoiding negative repercussions. Care must be taken not to explicitly identify individuals or groups as affected by mental disorders since this will often lead to stigma and discrimination. For example, approaches to avoid include making a call for survivors of sexual violence to identify themselves in order to receive support, identifying children of genocide perpetrators for support whose parent(s) are in prison, using community facilitators of an ethnic group that may have been involved in ethnic-based violence against the community, and repeated requests by outsiders for information and the retelling of traumatic experiences, especially if the communities will not see immediate benefits. Ultimately, there is no substitute for sensitivity, respect and active listening to the communities' views, and their own assessment of needs and what will work. Only if agencies avoid the temptation to impose their own criteria will communities be able to take ownership of the planned interventions and contribute to their sustainability.

Mental health versus psychosocial interventions: where should resources go? In most conflict affected countries, where there is capacity to treat mental health problems, services tend to be institution-based and reach only those that are severely affected. As discussed throughout this Toolkit, there is also a need to address psychosocial disorders and this requires the channeling of resources to the community level. But a poor, conflict-affected country faces a difficult dilemma—whether to allocate scarce resources to improve institution-based attention for the most severe cases, or channel additional resources to support community-based efforts.

Ideally, policies, approaches and resources should do both. Interventions should address both mental health and psychosocial disorders, with cross referral throughout the system and across the two approaches. Even successful community- or school-based psychosocial interventions need to be able to refer the more serious mental health cases to appropriate levels in the mental health care system. In turn, the effectiveness of the mental health system is greatly improved by having an effective referral system from the community and schools, but also to be able to refer the less severe cases down to these levels (see Section II.2 and Diagram 2).

It is important to keep in mind that for some countries, the interventions may begin small scale, in one or two regions of the country or focusing on one layer of the mental health system, then taking the lessons

learnt to scale up. It may also be necessary to begin with one sector, the one that is most ready (e.g., education), then gradually involve the other sectors. While an integrated and coordinated intervention effort is the ultimate goal, realistically, this is likely to be achieved in stages. Annex I presents core interventions, including objectives, types of interventions, stakeholders targeted and suggested indicators.

III. OPERATIONALIZATION: BASIC PILLARS

1. Stakeholder Analysis

Mental health and psychosocial interventions call for multiple actors within the three key sectors of health, education and social protection, the donor community, and a broad range of non-governmental actors. The latter include international and national NGOs, CSOs, CBOs and faith-based organizations. The first step for any agency planning a mental health and psychosocial program in a conflict-affected country is to carry out a stakeholder analysis to determine:

- Who is doing what;
- Resources available, such as specialized mental health and psychosocial personnel, training manuals and training capacity, sources of funding, and materials (e.g., vehicles, drugs, buildings);
- Target populations of stakeholders;
- Geographical coverage of stakeholders, especially in relation to affected populations, rural/urban distribution, and physical access;
- Challenges faced by each potential partner (e.g., resource constraints, security, relations with the government, ethnic or gender aspects); and
- Needs as perceived and identified by the potential partners.

The stakeholder analysis can be carried out through a SWOT/L (strengths, weaknesses, opportunities and threats/limitations) analysis of each potential partner. A useful reference is “*Strategic Planning for Non-Profit Organisations: A Practical Guide and Work Book*” by Michael Allison.

In order to carry out a stakeholder analysis, the following options, separately or in combination, can be considered:

- Visits to each of the key stakeholders to discuss approaches, experiences and constraints.
- Commission a consultant to carry out the stakeholder analysis, depending on preparation resources available and size of the proposed program. If funds permit, it is preferable to assign the stakeholder analysis to an independent expert, preferably with good local knowledge and familiarity with the government, and the donor and NGO communities. This could be integrated into the situation analysis so that there is no replication of efforts. The stakeholder analysis would be followed up by staff visits to the key stakeholders identified in the analysis.
- Stakeholder workshops are also useful since the information can be collected in one sitting, with follow up to each of the stakeholders to refine the data and information. An important advantage is that stakeholders also find out what others are doing and can improve coordination and establish new partnerships. The occasion of the workshop can also be used to promote awareness through the media.

The information gathered is then pulled together into a Stakeholder Analysis Report and/or database. Based on the stakeholder analysis, staff should have sufficient information to determine:

- Which key stakeholder could be part of the Coordinating Group (discussed below);
- Which government sector could take the lead, based on whether the sector ministry or agency considers mental health as a priority, has developed some policies and protocols, and has some capacity and commitment to take the lead in the coordination effort;

- Resources available in-country and hence where the intervention can help to fill resource gaps (e.g., training, drugs, equipment); and
- A possible referral network/system, and its strengthening, to link the mental health and psychosocial dimensions.

Box 2: Summary: Stakeholder Analysis

1. Determine what approach is going to be used to carry out the stakeholder analysis.
2. Develop TORs for the stakeholder analysis and have it carried out using the SWO/L approach.
3. Using the results, determine which government sector will take the lead.
4. Determine which stakeholders are going to be part of the Coordinating Group (discussed below)

2. Creating a Coordinating Group and Formulating a Strategy

A Coordinating Group is typically led by the Ministry of Health, the Ministry of Education or by the ministry or agency that deals with social protection, but should also include participation from the sectors not taking the lead. The Coordinating Group would also generally include key UN agencies (e.g., UNHCR, UNICEF, WHO), key bilateral donor agencies active or interested in mental health, as well as key NGOs and other CSOs, active in the implementation of mental health and psychosocial programs and/or in advocacy work in this area. The challenge is to establish a Coordinating Group small enough to ensure a concentrated and coordinated effort, while not discouraging others who have something to contribute.

Once the Coordinating Group has been established, one of the first tasks will be to agree on basic principles, standards and guidelines, including some form of regulatory mechanism. In most countries, the government would be expected to play the regulatory role, but where government capacity is weak or non-existent the Coordinating Group may need to agree on minimum regulation and collective enforcement until a government agency can begin to take on this role.

The Coordinating Group would then generally agree on:

- *Who will do what:* such as one agency taking the lead in developing the training curriculum and training staff, another focusing on strengthening the referral system;
- *Who will work where:* agreeing on geographical distribution to ensure better coverage of rural and urban populations, and avoid concentration on major urban areas and duplication of efforts;
- *Who will work with which target groups:* since the mandates or funding sources of some agencies, especially NGOs and UN agencies, often specify their target populations (e.g., children, women, physically disabled, IDPs and refugees, ex-combatants), the Coordinating Group can help to identify gaps in coverage in light of different mandates which a less constrained agency such as the World Bank can seek to fill;
- *What is included and what is not:* it is essential to agree early in the process on what is feasible, in light of available resources, expressed needs of the population, and skills and capacity available in the country (which can be built on)—prioritization requires setting objective limits; and
- *Mobilizing and sharing resources:* bearing in mind that some members of the Coordinating Group may be competing for resources, the Group should explore the extent to which joint approaches to funding may mobilize additional resources. Examples include the Uganda Psychosocial Core Team, that was able to mobilize funding from UNICEF with a joint proposal, and the Children’s Psychosocial Consortium of Afghanistan that mobilized funding from USAID. Funding partners generally prefer to support consortia or networks, rather than having to deal with each small program separately. In addition, the Coordinating Group should review the criteria and eligibility for funding under Multi-Donor Trust Funds, that are typically set up to support and coordinate donor funding for post-conflict reconstruction. Access to this and other

Trust Funds will likely be enhanced by a consortium approach sponsored by the Coordinating Group.

The Coordinating Group should also adopt a strategy for communicating with community representatives, government officials, and international partners and donors. The Coordinating Group should seek representation and a voice at donor meetings, such as Consultative Group Meetings and Donor Roundtables, as well as other national forums designed to build consensus on national priorities and sectoral strategies. It should also build contacts with the media in order to raise awareness and publicize efforts to deal with mental health and psychosocial disorders, especially to showcase successes.

Box 3: Summary: Creating the Coordinating Group

1. Identify the lead government sector.
2. Create the Coordinating Group made up of key stakeholders.
3. Determine priorities.
4. Establish principles, standards and guidelines, and regulations if appropriate.
5. Agree on first steps to develop a strategy and the role of each partner.

3. Baseline Data and Situation Analysis

Establishing baseline data and the situation analysis is important to:

- Gauge the government's commitment to addressing mental health and psychosocial disorders;
- Identify key stakeholders/partners and their various roles and activities;
- Establish the extent of the mental and psychosocial disorders;
- Assess knowledge, attitudes and practices in the country context in relation to mental and psychosocial disorders;
- Determine available mental health and psychosocial interventions, challenges and gaps;
- Assess costs for these interventions;
- Identify the most affected geographical regions and the most vulnerable populations; and
- Determine priorities.

Obtaining data is generally a difficult challenge. Good data and comprehensive surveys are rarely available in most post-conflict settings. However, in addition to checking with national health authorities and reviewing any available studies, there are a number of sources that can be consulted to get a sense of possible vulnerable groups. These include: (i) contacting humanitarian agencies involved in refugee and IDP camps who may have some survey data on prevalence inside camps; (ii) consulting the Post-Conflict Needs Assessment to determine if any effort was made to ascertain mental health needs—but since this is rarely the case; (iii) contacting the health specialists that participated in the Needs Assessment who may have gathered information on mental health conditions; (iv) determining if attempts were made during encampment in the disarmament and demobilization program to ascertain and/or address the mental health of ex-combatants;⁵ and (v) contacting UN agencies and international NGOs that are often active in the mental health field (e.g., WHO, UNICEF, UNHCR, Save the Children, International Refugee Council, Care International) and who in turn may be partnering with or connected to local groups.

Qualitative sources should also be consulted. However, a number of caveats should be kept in mind in reviewing available quantitative and qualitative material:

- Since some agency studies are used as fund-raising tools, they may over-state prevalence rates in their mandated or target populations. The data may also come from small samples (e.g., only a few villages, a couple of schools), a narrow institutional source (e.g., clinical/hospital patients) or special groups (e.g., ex-combatants, IDPs) which may bias the results.

- Reporting bias may affect data from service providers. Often, establishing a service in a community raises community awareness and willingness by individuals to seek care. Thus, the prevalence of mental and psychosocial disorders would appear higher in this community as measured by those seeking care, compared to a community with no service providers.
- Where no data is available, it may be possible to extrapolate from other conflict-affected countries. However, this must be done with care since countries may not be comparable or some countries may be very sensitive about being compared to others they perceive as not being similar. Comparisons are best done when the countries are in the same region and have similar conflict experiences (e.g., using data from Rwanda to estimate possible prevalence rates in Burundi).

It is generally not advisable to allocate major project resources to collect data. There are many complex issues with under-reporting and sensitivities in surveying communities about mental health problems. Instead, teams working on mental health and psychosocial programs should support: (i) qualitative studies that can be designed with greater cultural sensitivity and that can frame requests for information as part of broader studies of socio-economic conditions and vulnerabilities; and (ii) focus on influencing national efforts to improve statistical systems and living standards survey capacity, advocating the inclusion of mental health issues. An important entry point is the PRSP process. The Coordinating Group and staff working on mental health issues should try to ensure that civil society representatives and advocacy groups working on mental health be included in PRSP consultations and participatory processes. These advocates and the Coordinating Group should encourage the inclusion of mental health issues in the poverty diagnosis that informs the PRSP, as well as the development of specific policies, programs and monitoring indicators to be included in the final PRSP. Given the high visibility of the PRSP among donors, the government and civil society, good coverage of mental health and psychosocial issues in the PRSP can generate considerable support and country ownership.

An additional entry point to consider is Bank ESW or other analytical products. Poverty and vulnerability assessments in conflict-affected countries can include components on mental health, as for example in the case of Burundi's *Poverty and Vulnerability: Interim Report* (draft, June 2004), which includes a section on the impact of the conflict on psychological health, disaggregated by quintiles. Bank support for living standards surveys can also include modules on mental health and psychosocial conditions. Results can be used to design Bank-supported mental health interventions, or inform the design of health, education or social protection projects.

After obtaining as much quantitative and qualitative data as possible, this information is analyzed by the Coordinating Group, and used to develop a longer-term strategy with clear objectives, priority populations and activities, coordination mechanisms, and a monitoring and evaluation plan. The strategy should specify broad indicators for the overall strategy, but each partner would generally develop more specific indicators in line with its requirements and mandate. The indicators should be consistent with the priorities determined by the communities.

Box 4: Summary: Baseline Data and Situation Analysis

1. Collection of qualitative and quantitative data.
2. Coordinating Group reviews data and uses to define the strategy.
3. Develop action plan identifying the roles of the various stakeholders.
4. Adopt broad program indicators defined by the Coordinating Group.

4. An Integrated Approach: What to Look For

Ideally, mental health and psychosocial interventions should be linked and integrated across key human development sectors and throughout relevant government structures. This is rarely the case in post-conflict countries and a gradual and phased approach will often be necessary. The section below suggests what to look for in each sector.

Health Sector

- Sexual and reproductive health and rights:
 - ↳ Prevention of sexual abuse as well as violence against women, including female genital mutilation;
 - ↳ Integration of emergency services into trauma units assisting victims of violence; and
 - ↳ Recognition and management of the psychological effects of sexual abuse and violence against women.
- Health education and promotion:
 - ↳ Prevention of alcohol and drug abuse
- School health:
 - ↳ Screening and management of common mental and psychosocial disorders;
 - ↳ Training of teachers to provide Helpful Active Listening for children with milder mental and psychosocial problems;
 - ↳ Providing teachers with the skills to recognize children with severe problems so they can be referred for more specialized treatment, and listing resources available in their community; and
 - ↳ Training teachers to facilitate Psychosocial Child-to-Child Programs for mutual support.
- Mental health:
 - ↳ Mental Health Coordinator and a Unit in the Ministry of Health to oversee mental health policies and activities, and to lead coordination with key stakeholders and partners;
 - ↳ Integration of mental health into primary health care, including the training of primary health care workers to recognize and manage common mental disorders often associated with conflicts (depression, anxiety, PTSD);
 - ↳ Formulation of standards and guidelines for the provision of mental and psychosocial services;
 - ↳ Establishment of a Coordinating Group for mental and psychosocial disorders;
 - ↳ Ensuring the availability of the essential mental health drugs; and
 - ↳ Establishment and/or strengthening of data collection and monitoring systems.

Education Sector

- Support for the training of teachers to recognize children with mental and psychosocial disorders;
- Counseling included in all basic teacher training;
- There may be a need to establish a few special schools and/or vocational training institutes for ex-abductees and ex-child soldiers, since they may not integrate well into regular schools; and
- Establishment of a data collection system to track those with mental and psychosocial disorders.

Social Protection Sector

- Identification of orphans and vulnerable children, including children with physical disabilities, children in child-headed households, children of people in prison for war related crimes, street children;
- Identification of other vulnerable populations such as those in IDP and refugee camps, war veterans, widows, sexual assault survivors, those with physical disabilities caused by conflict;
- Data collection to establish the population in need and being served; and
- Coordination of NGOs working in the area of social protection and/or child protection.

Local Administration

- Inclusion of mental health and psychosocial protection in local-level development plans; and
- Coordination of the local-level mental health and psychosocial intervention partners.

Box 5: Summary: Key Policy Issues

1. Identification of the key sectors.
2. Meet with staff from key sectors to discuss mental health and psychosocial issues.
3. Review of sector policies and strategies to assess commitment to mental health and psychosocial issues.
4. If government is interested, Coordinating Group should offer to work with key government staff to include mental and psychosocial issues in relevant policies and strategies.

III. OPERATIONALIZATION: THREE DIMENSIONS

1. DIMENSION ONE: Basic Elements of Mental Health and Psychosocial Interventions

This Section addresses briefly the various activities that can be included in a package of services to address mental and psychosocial disorders for conflict-affected populations. Not all activities would be included—they are a menu of options.

Mental health as part of primary health care. Some activities include:

- Integration of mental health as an essential component of the government’s Health Sector Policy and/or Health Sector Action Plan;
- Identification of a package of essential mental health services to be provided to conflict-affected populations;
- Provision of specialized services to those who may be more vulnerable such as survivors of violence (e.g., rape, genocide), those living in IDP and refugee camps, conflict amputees;
- Establishing or providing support to the Mental Health Unit in the Ministry of Health;
- Creation of and support to the Mental Health Coordinating Committee.
- Development and dissemination of standards and guidelines for the provision of mental health and psychosocial interventions;
- Development of training manuals for all levels of care;
- Training of primary health care workers to recognize and manage common mental disorders; and
- Ensuring that essential mental health drugs required to manage the identified essential package of mental health and psychosocial services are included in the Essential Drug List, and are available at all health units.

Counseling is a controversial area. It is a term that encompasses “counselors” who have been trained for just a few days to others who may have received up to nine months of full-time training. Training may also be unsystematic and provided without following a standard manual. It is thus imperative that the Coordinating Group agree on:

- What the standard counseling training will be, including hours of face-to-face time, supervised client support before certification, and the basic principles of the training provided;
- Consider whether local staff themselves will need psychosocial counseling and treatment before they can support community efforts;
- A standardized core content for the training manual which can then be broadened to include specialized sections such as for rape survivors, children, or ex-combatants; and
- Who will be responsible for certification and regulation of training agencies.

Group support is generally more appropriate in situations where affected populations are large but where the effects are mild to moderate. Group support may also be used in combination with individual support. A rape victim may benefit from one-on-one counseling, but will also benefit from sharing experiences in a group with other women victims, since this can minimize the stigma and help the victim realize she is not alone. In many cultures, however, women would not feel comfortable sitting in a group discussing their problems. They may feel more comfortable if they come together to carry out an income-generating activity or a cultural event, and be better able to share experiences and develop group solidarity. Group support must be facilitated by a local counselor or social worker, in order to ensure that no harm is done and that a healing process is taking place. Whatever the approach taken, and as in all cases discussed in this Toolkit, the views of the victims and their communities should always be carefully sought to determine appropriate support modalities.

Communities' own **rituals and traditional healing** can often help people affected by trauma reintegrate back into normal life. Many of these rituals take the form of symbolic cleansing, of washing away the blood or the traumatic memories, of driving away bad spirits and of calling ancestors for assistance. While rituals and cleansing ceremonies can be very helpful in dealing with milder forms of psychosocial stress, and assist communities in coping with returnees from conflict, they should be approached with caution. In some instances rituals may be damaging, as for example when rituals involve female genital mutilation performed by members of secret societies. When in doubt agencies should consult grassroots NGOs and women's groups to assess local rituals.

Helpful Active Listening or Listening and Helping refer to the ability for someone to listen to a person's problems and work with them to try to resolve them. It is used in the context of the skills provided to teachers, women community leaders, religious leaders or others who may be identified as communities' own resource persons (CORPs). CORPs can support children who may show signs of distress, women who may have been sexually abused, and victims of domestic violence. Sometimes, just having someone willing to listen will go a long way to resolving the distress.

As in counseling, it is important to establish:

- The core content of the training;
- The standards for training, including essential face-to-face time, supervised client support time and provision of support supervision;
- Which government sector will certify and regulate the training; and
- Where referrals will be made for those who need more comprehensive support.

Early Child Development (ECD) provides health, nutrition and cognitive development to 3-6 year-olds. The value of integrating the psychosocial component in the ECD program for conflict-affected populations is that the children may have mild developmental impairments due to limited stimulation from their mothers. Due to parental stress, mothers may not interact with the children, the children may not have as much freedom to roam around, explore and play, and receive little support from older siblings who may be forced to become income-earners for the household.

The ECD Component of the Burundi Second Social Action Program ECD offers some lessons:

- Creation of Circles of Mothers at each village;
- All 3-6 year-olds in the village were registered;
- A psychologist, working with an Early School Teacher and with technical supervision from the Bank, carried out an evaluation of the knowledge and skills of the Circles of Mothers, which was used to develop a curriculum, training manual and facilitator's handbook;
- Trained two mothers from each Circle to be facilitators;

- Early Child Learning Centers were run every morning in a building donated by the community; the community also contributed a snack and agreed on contributions of grain or other staples to compensate the unremunerated facilitators for what they lost from not working their fields; and
- The Bank’s contribution was to pay for the consultants that developed the manual and trained the mothers, training of the facilitators of the Circles, roofing material for the Centers, and very basic pedagogical materials.⁶

Kid’s Clubs are a very informal opportunity for 6-14 year-olds to come together to dance, sing, play and enjoy a moment of being children. Due to the insecurity caused by conflict, children may have no safe spaces in which to play and interact socially with other children. Kid’s Clubs, based on the Salvation Army Model of Bulawayo, Zimbabwe include: a sponsor, usually an adult at whose home they can meet; 2-3 Youth Leaders, who are usually young people who have been through some basic training on how to facilitate children’s activities; and a fixed meeting time at least once a week. The Clubs are very cost-effective, since neither the sponsor nor the Youth Leader are remunerated, and no inputs are required except for some basic instruments that can be improvised from discarded materials.

The Clubs can be adapted to different contexts. In the West Bank, an NGO organizes an annual summer residential camp that brings together children from all over the West Bank and Gaza to play and participate in artistic activities. These activities help to re-establish a sense of normalcy for children living in violent and insecure environments due to conflict.

Art as healing can assist children to channel some of the emotions associated with trauma without forcing them to confront or recount the trauma. These methods can be especially effective when facilitated by trained therapists. Painting, for example, can provide a way to express emotions. Children can begin by drawing what they remember of the conflict/traumatic event and talk about what they draw. As healing takes place, they draw pictures to represent their current state, and toward the end of the program they begin to draw what they see as their future.

Sports can be used to help children begin to learn again how to interact with each other. Ex-combatants and ex-child soldiers have often lost the ability to trust others, find it difficult to work as a team, and have to learn how to handle frustrations. This can be re-learned through closely supervised sports activities.

For younger children, understanding the loss of a loved one can be difficult. **Stories** can be used to transmit an important message as well as to help children to discuss the emotions related to this loss. An example is the story of “*A Little Elephant Finds His Courage*”, developed by Nancy Baron while working with children in Nepal. It has been adapted for use in other parts of the world.⁷

Box 6: Summary: Basic Elements of Mental Health and Psychosocial Interventions

1. Select basic package of services to be delivered.
2. Adopt a multi-sector approach.
3. Base the approach on the situation analysis, targeting, available resources, and prioritization.
4. For each activity selected, ensure that no harm is done. Certification and regulation are essential.

2. DIMENSION TWO: Programming Issues

Duration of Support

A determination has to be made as to how long the support should last. The funding cycle for most NGO projects is 3-5 years. When partnering with an NGO, it will be important to determine the duration of support for each intervention—will it coincide with the NGOs funding cycle or will it be phased out in some areas and begun in other areas during the funding cycle? In some cases the goal may be to

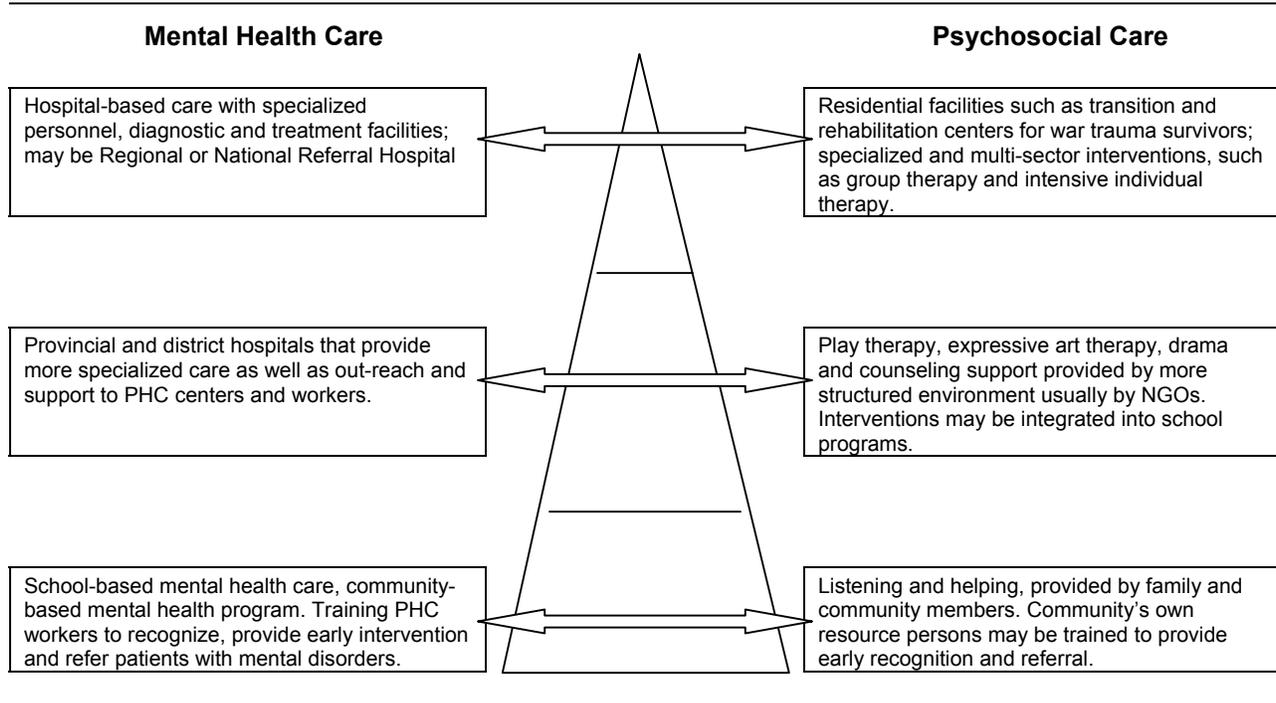
incorporate interventions into ongoing government programs, as for example in the cases of Helpful Active Listening, or mental health services in primary health care systems. In these cases, design of the intervention should include arrangements to transition from NGO-support to integration into government programs.

In other cases, programs may be specifically designed for limited periods, as for example demobilization and reintegration programs for ex-combatants, and resettlement and reintegration programs for IDPs and refugees. Even when these programs are designed for discrete periods, if they provide some support for mental health they need to be coordinated with broader national and community efforts on mental health and psychosocial programs to ensure there is effective follow up where needed.

Mental Health and Psychosocial Interventions—An Integrated Approach

Both mental health and psychosocial disorders have three major levels of severity, mild, moderate and severe. Interventions for both kinds of disorders are available for the three levels of care, primary, secondary and tertiary. The relationship between mental health and psychosocial interventions is illustrated in Diagram 2.

Diagram 2: Relationship Between Mental Health Care and Psychosocial Services



In assessing the scope for mental health and psychosocial interventions, and the links between the two, it will be important to bear in mind:

- The inter-dependence of services with each and across levels. Whereas psychosocial programs can provide services in the communities, there is a need to have a mental health worker in a clinic able to diagnose and treat those with severe mental disorders.
- One level of care alone would not be sufficient to address all the mental health and psychosocial disorders in a community. While focusing services at the community level maximizes coverage, even for psychosocial disorders there needs to be a higher level where referrals can be made.
- As mentioned earlier, resources are often allocated to institutions, whether dedicated to mental health care or to psychosocial interventions. Institutions serve a very small percentage of those who may be

affected yet may not be as cost-effective. Data from the *Costs of Projects for Orphans and Other Vulnerable Children: Case Study in Eritrea and Benin* (Prywes et al. 2004) found the average annual cost per child for institutional support to be high relative to family based interventions. The average annual economic costs per child for institution-based care were US \$1,300 to US \$1,900, compared to US \$100 for community based care in Eritrea.

- If the aim is to bring as many of those affected as possible to the point where they can effectively participate in development efforts, then it is advisable to target those with mild to moderate disorders where the likelihood of recovery is higher and where interventions are also cost effective. As examples, it is more cost-effective to treat depression, whether with medications or with cognitive behavioral therapy, than to treat schizophrenia; it is more cost-effective to provide psychosocial care to children through school-wide programs and community support than to institutionalize orphans and vulnerable children.
- As programs are established, as mild to moderate cases are managed and pass out of the system, and as the delivery system is gradually strengthened, then there can be greater focus on those with more severe disorders. There may also be other agencies, such as WHO, willing to focus on care for severe cases.

Urban/Rural

The majority of the population in conflict-affected countries are in rural areas. At the same time, rural areas are often under served, difficult to reach and may be still insecure. Reaching populations in rural areas is a challenge. One approach is to select one urban site and one rural site for initial implementation, then as experience grows, lessons learnt can be used for scaling up to other areas.

Cultural Context

As emphasized throughout this Toolkit, cultural context is extremely important. It determines health-seeking behavior, attitudes and practices toward people with mental and psychosocial disorders, including by professional staff, and the families and the community at large. Cultural attitudes determine stigma, even at the policy-making level. Great care and sensitivity are required, even in discussions with policy-makers or terms used in Bank studies and reports. In some countries, the term psychosocial is preferred to mental health or mental disorders. The latter two are often associated with severe and disabling psychotic mental illnesses.

Box 7: Summary: Programming Issues

1. Determine the duration of support.
2. Determine whether interventions will be in one area or will change during the project cycle.
3. Determine whether it will be a mental health, psychosocial intervention, or both.
4. Every effort must be made to reach those in the rural areas.
5. Local knowledge, attitudes and practices must be taken into account during the planning stage.

3. DIMENSION THREE: Program Process Components

For each of the program elements discussed above, critical process components integral to successful implementation include:

- **Policy and standards.** Even when there is no policy framework in place, but the government indicates interest, an initial step can be to develop a three-year strategy, and rolling annual work plans. The strategy and work plans can provide broad directions to support collaboration and resource mobilization. As commitment and capacity improve, the strategy and work plans can be easily updated and eventually serve as the basis for national policies and strategies.
- **Training** should include developing/reviewing curricula, and training trainers for the different cadres of staff that will be required. It helps to develop a training plan that includes how many

staff need what kind of training, determine whether it will be in-service training or whether review of the basic training school curricula will be included.

- **Support supervision** should be included in every activity. It should involve staff from the higher levels of care interacting regularly with lower levels of care to provide continuing education, discuss problems that the lower level staff may be experiencing, review client/clinical records, as well as seeing those patients referred by the lower level staff.
- **Coordination of services** between the different sectors and between the different providers is important to avoid duplication, more efficient resource use and effective service provision. An example is two agencies or NGOs providing psychosocial services to ex-combatants. One may have a reception shelter but no staff to work on community care, while another may be focusing on community-based support. Coordination and sharing of resources would clearly improve the effectiveness of both NGOs and the services provided to ex-combatants.
- **Referral** is a key element that links the system vertically and horizontally. For example, teachers providing Helping and Listening Skills to school children may need to make referrals to Kid's Clubs or the nearest mental health facility. A psychiatrist who makes a diagnosis of depression in an urban area can refer the patient to community psychosocial programs once the depression has been stabilized.
- **Monitoring** is important to assess impact. Ideally, monitoring should be included in the strategy from the start, so that an agreed monitoring system is established. This need not be overly complicated at the beginning and can be refined as experience grows. It may be that all partners send their annual reports to the lead government counterpart, it could involve a regular schedule of meetings to share achievements and challenges and report on planned activities, which could be hosted by the Coordinating Group.
- **Evaluation** is often overlooked and not included in the strategy document. Yet this is crucial, especially for a field such as mental and psychosocial health, where there is little solid evaluation of effective programs and where government and other stakeholder support may be weak due to the multitude of competing post-conflict priorities. If objectives, activities and outputs are agreed and included in the strategy document, priority should be placed on developing a set of good impact indicators, and agreement on the timing and methodology for a comprehensive evaluation of the interventions supported by the strategy. The latter could include an outside expert(s) who would be more neutral. Evaluation results need to feed into the next planning cycle, highlight and document major achievements (especially in terms of cost-effectiveness and impact), as well as challenges. Evaluation results and lessons should be broadly disseminated beyond the members of the Coordinating Council, locally and internationally.

Box 8: Summary: Program Process Components

1. Define objectives, core interventions, stakeholders and monitoring indicators (examples in Annex I).
2. Determine the elements above as they apply to children and women (examples in Annex II).

4. Research Needs

The evidence for investing in mental and psychosocial interventions is still being built up. The following are some of the areas where further work is needed in order to strengthen the quality and effectiveness of mental and psychosocial disorders programming. They can be included as small components in projects.

- Whether and how mental health and psycho-social interventions influence the formation of positive social capital, and links with peace and reconciliation efforts.
- The link between post-conflict mental and psychosocial disorders, especially among women, and the health and educational outcomes of their children. This would make a case for investing in the mental and psychosocial well being of women in order to influence the health, nutritional and educational outcomes of their children.

- Further analysis of costs and effectiveness of mental health and psychosocial interventions that can be developed for populations affected by conflict. Evaluations of the successes and challenges and documentation of the findings would be critical to determine how future programs can be improved.

5. Conclusion

This Toolkit outlined the prevalence of conflicts, the link between conflicts and development, the psychosocial and mental health consequences of conflicts, and provided a step-by-step approach to initiating, planning, implementing, monitoring and evaluating mental health and psychosocial programs.

The Toolkit illustrates that:

- It is possible to develop mental health and psychosocial programs in different sectors and with very different approaches.
- In all interventions, there is a need to ensure coordination within the health sector (between primary health care and mental health) and across sectors (education, health, social protection).
- Collaboration between the government, donors, NGO and CSOs is vital to the success of mental health and psychosocial programming.

One important gap is the lack of well-documented program evaluations, especially in terms of impacts, sustainability and cost-effectiveness. These would help in the design of outcome/impact indicators that would be useful for scaling up or replication of programs.

This Toolkit is one step in building the capacities of stakeholders working to address the mental and psychosocial consequences of conflict. To increase the usefulness of the Toolkit, practitioners are asked to share challenges they face, lessons they have learnt in implementing programs, and any other comments directly related to the Toolkit. The Toolkit will be regularly updated to reflect these inputs and lessons.

Annex I: Core Interventions and Indicators

Objectives	Core Interventions	Stakeholders	Indicators
Establish a Mental Health/Psychosocial Working Group			
To collaborate and coordinate in the planning and implementation of mental health and psychosocial issues	<ul style="list-style-type: none"> Identify key players, government, donors, NGOs, community leaders Facilitate regular meetings 	<ul style="list-style-type: none"> Government: health, education, social welfare Agency planning intervention Donors with interest in mental health and psychosocial issues NGOs UN Agencies: WHO, UNICEF, UNHCR 	<ul style="list-style-type: none"> TORs Key stakeholders identified Funds Meeting reports
Establish the Extent of the Problem and the Services Available			
Gain understanding of service needs, most vulnerable populations, available services (quality, quantity, distribution and access)	<ul style="list-style-type: none"> Carry out a needs assessment including qualitative and quantitative elements Tools: WHO, HPRT, SCF, CDC, TPO, HNI 	<ul style="list-style-type: none"> The Coordinating Committee as identified above 	<ul style="list-style-type: none"> TORs Consultants identified Funds committed Report disseminated
Access to Quality Mental Health and Psychosocial Services			
Increase the numbers of health workers and others who can recognize and manage common mental health problems	<ul style="list-style-type: none"> Define basic package of essential mental health care services Identify trainers Develop standards and guidelines Develop training curricula for various cadres/levels Carry out training and supervision 	<ul style="list-style-type: none"> Primary health care workers Community-based health and rehabilitation workers 	<ul style="list-style-type: none"> TORs Basic package of mental health and psychosocial services identified Trainers identified Guidelines available Curricula available
Increase number of community workers, teachers and other non medical resource persons able to recognize and manage common mental health and psychosocial problems	<ul style="list-style-type: none"> Identify NGOs and government sectors carrying out mental health and psychosocial activities Agree on core interventions for which to develop guidelines Develop essential components of the curricula, adapt for different personnel (teachers, counselors, child protection officers) Support for NGOs to carry out training 	<ul style="list-style-type: none"> NGO administrators NGO service providers School Heads and counselors Min. of Education HQ officials Social workers Teachers Child protection officers Responsible officers in UNICEF, UNHCR, WHO 	<ul style="list-style-type: none"> Minutes of meetings Sharing of trainers Participation of different stakeholders in training Standardized training curriculum is available

Annex I: Core Interventions and Indicators (continued)

Objectives	Core Interventions	Stakeholders	Indicators
Establish and support referral system	<ul style="list-style-type: none"> Identify key referral agencies and points across the sectors Provide support and upgrading (eg. training) to referral system 	Service providers from government and non-government sectors, including teachers, health and social workers, women's and human rights organizations	<ul style="list-style-type: none"> Referral criteria available Referral points known by providers Number of referrals being made at each point and across sectors and agencies
Establish and support supervision system	<ul style="list-style-type: none"> Establish supervision chain Support supervisory process 	Service providers (as above)	<ul style="list-style-type: none"> Support supervision guidelines established and followed Funds disbursed to facilitate support supervision

Annex II: Children's and Women's Mental Health and Psychosocial Services

Objectives	Core Interventions	Stakeholders	Indicators
Children			
Establish services for children and parents in order to prevent the development of mental disorders	<ul style="list-style-type: none"> Identify and coordinate with key stakeholders eg SCF, UNICEF, Ministries of Education, Social Protection Identify the most vulnerable and their needs Develop programs to reach all children in the school system; teacher training, parenting sessions Develop specialized programs to reach the most vulnerable 	<ul style="list-style-type: none"> Child protection officers Social workers Teachers NGO service providers 	<ul style="list-style-type: none"> % children reached with the broad intervention % of vulnerable reached with targeted intervention No. of referrals made to specialized care by the child protection officers, social workers, teachers and NGO service providers
Women			
Ensure that the needs of women are taken into account by gender-sensitizing interventions (e.g., address issues of sexual violence, widows, demobilized girls)	<ul style="list-style-type: none"> Identify and coordinate with key stakeholders (e.g., UNIFEM, UNICEF, Ministry of Health, Ministry/agency for women's affairs) Identify most vulnerable and their needs (e.g., victims of sexual violence) Develop programs to reach as many women as possible, eg, through women's groups Develop specialized programs to access most vulnerable 	<ul style="list-style-type: none"> Social workers Health care providers NGO service providers Legal aid workers Community workers 	<ul style="list-style-type: none"> % women reached with the broad intervention % of vulnerable women reached with targeted intervention No. of referrals made to specialized care by legal aid workers, community workers and NGO service providers

Annex III: Examples of Best Buys

Objectives	Core Interventions	Stakeholders	Indicators
Bosnia-Herzegovina			
Integrating Mental Health into Primary Health Care (PHC)	<ul style="list-style-type: none"> Assessment of knowledge and skills of primary care physicians Development of training curricula Training primary care physicians Post-training assessment Support supervision 	<ul style="list-style-type: none"> Primary care physicians Patients with mental disorders 	<ul style="list-style-type: none"> Improved knowledge and skills of primary care physicians Increased numbers of patients seen Mental health integrated into the CBR/PHC program
Uganda			
Northern Uganda Psycho-social Needs Assessment and Integration in District Development Activities	<ul style="list-style-type: none"> Exploratory workshop Core team formed Needs assessment carried out Dissemination of results Key areas for intervention identified Participatory planning at the district level Resource mobilization Implementation of programs 	<ul style="list-style-type: none"> Ministry of Health, Ministry of Social Welfare District Development Committees NGOs (AVSI, Red Barnett, HAR, TPO) 	<ul style="list-style-type: none"> Comprehensive situation analysis available Regional district priorities identified District psychosocial plans developed and implemented Commitment of district funds to psychosocial activities

Annex IV: A Taxonomy for Orphans and Vulnerable Children from the Perspectives of Conflict and Mental and Psychosocial Disorders

CHILDREN	AIDS Affected	Conflict Affected	Street Children	Children in Worst Forms of Labor	Disabled Children
Orphaned	Evidence of spread of HIV/AIDS with armed forces. Orphaned children more susceptible to HIV/AIDS. Many parts of Africa have double burden of HIV/AIDS as well as conflicts.	War orphans are more vulnerable to abuse, and to lack of access to education and to health services	Some of the street children are orphans. In rural areas, they wander around the villages. Likely to abuse drugs and alcohol, some are sexually abused.	Orphaned children may end up in the worst forms of labor. In conflict situations, orphans may become child soldiers.	Conflict situations may increase the numbers of children with physical disabilities (mine victims, amputees in Sierra Leone). Poor health services may lead to polio, epilepsy, cerebral palsy, mental retardation.
Separated from Parents	Due to breakdown of social support systems during conflict, orphans lack community support for HIV/AIDS.	Displaced and unaccompanied refugees. Increase in number of child headed households	Children separated from parents as a consequence of conflicts are at high risk of ending up as street children.	Children separated from parents are at risk of being recruited as child soldiers	Many children with disabilities are abandoned by their parents during times of crisis.
Living with Dysfunctional Parents	Children living with parents who are injured or traumatized by the war do not get adequate stimulation	Children living with parents who are injured or traumatized by the war do not get adequate stimulation	Stress in the home resulting from the conflict may lead to abuse of children, who in turn may choose life in the street to escape abuse.	Children running away from dysfunctional homes are easy recruits for armed groups.	Children living with dysfunctional parents are at risk of developing emotional disorders, specially if traumatized.
With Needs Beyond Parental Care	Not possible to have PMCT initiatives in conflict situations. Greater number of children born with HIV during situations of conflict	Ex-child soldiers and ex-abductees, which increase as a result of conflict, generally require special attention.	Children who may be abusing drugs, involved in crime, and young female ex-abductees or ex-combatants with children.	Child soldiers, abductees still under the control of their captors, and girls forced to marry rebels.	Amputees and mine-affected children.

Source: Adapted from the taxonomy of Anne Keilland.

¹ The Bank's assistance to conflict-affected countries is guided by Operational Policy 2.30 on Development Cooperation and Conflict, approved by the Board of Directors in January 2001.

² See Mollica et al 1999 and 2001; Scholte et al 2004; and Heise et al 1994.

³ An ongoing research project is analyzing the prevalence of depression among the adult population in post-conflict Bosnia-Herzegovina and explore the impact of mental health on labor market productivity and use of health care services (K. Scott and M. P. Massagli).

⁴ A Toolkit on Physical Disabilities and Conflict is being prepared in parallel to this Toolkit and should be consulted for more targeted programs on physically disabled populations.

⁵ See for example Gleichmann et al. (2004) for a discussion of psychosocial and mental health care during disarmament, demobilization and reintegration programs.

⁶ Regarding impact, the full results are in the Paper on *Early Child Development in Burundi* (Coury et al. 2003). They note that children who attended the pre-school program tended to perform better during their years at primary school.

⁷ N. Baron. XXXX. *A Little Elephant Finds His Courage*. New York: SIDRAN. The book includes a separate Discussion Guide and list of recommended art projects to encourage expression.

This toolkit draws on the experience of five years of mental health activities for conflict-affected populations carried out by the World Bank as well as the experiences of key partners from lead UN and international agencies. It is prepared in response to the expressed need of Bank task managers.

The toolkit begins with a general introduction that sets the stage for mental health and psychosocial interventions in the context of conflict affected populations. A discussion of programming issues then follows which is then followed by two sections that outline the steps to take to operationalise mental health and psychosocial interventions.

The toolkit is dynamic and will change over time. This first iteration will be updated and reviewed as and when further experiences become available, Task Managers use it and provide feedback, and further resources become available and can be included as annexes.