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Mental Health and Conflicts:

Conceptual Framework and Approaches

Florence Baingana, Ian Bannon and Rachel Thomas

February 2005

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HEALTH, NUTRITION, AND POPULATION
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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Mental Health and Conflicts:
Conceptual Framework and Approaches

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Abstract: The paper provides an overview of the Bank's role in conflict and development, and explores the links between poverty, social capital and mental and psychosocial disorders in conflict settings. The premise of the paper is that increased understanding and targeted interventions to deal with mental health can play an important role in effective post-conflict reconciliation and reconstruction. It also argues that there are effective approaches that can be adapted to different conflict settings. The paper presents a conceptual framework based on experiences in and outside the Bank that can help guide interventions and approaches to address mental health and psychosocial disorders in conflict-affected countries. The paper briefly examines mental health approaches adopted by the Bank in West Bank and Gaza, Bosnia-Herzegovina, Uganda, Burundi and Afghanistan. These brief country illustrations suggest there are a variety of approaches and a growing body of experience on which Bank country teams can draw. The paper concludes by noting areas where additional research would seem appropriate and presenting suggestions for further Bank analytical and operational work.

Keywords: mental health, mental disorders, conflicts, psychosocial disorders, programming services

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention and Control Program (CARE International)
BPHS	Basic Package of Health Services (Afghanistan)
CAS	Country Assistance Strategy
CBO	Community-Based Organization
CDC	Center for Disease Control
CPR	Conflict Prevention and Reconstruction
GDP	Gross Domestic Product
GHQ	General Health Questionnaire
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
HTQ	Harvard Trauma Questionnaire
HNI	HealthNet International
HPRT	Harvard Program in Refugee Trauma
ICF	International Classification of Functioning and Disability
IDPs	Internally Displaced Persons
IRC	International Rescue Committee
MOH	Ministry of Health
MSF	Médecins Sans Frontières
NUPSNA	Northern Uganda Psychological Needs Assessment
NGO	Non-Governmental Organization
OED	Operations Evaluation Department (World Bank)
PCF	Post-Conflict Fund
PCP	Primary Care Physician
PHC	Primary Health Care
PNA	Palestinian National Authority
OVC	Orphans and Vulnerable Children
PTSD	Post-Traumatic Stress Disorder
STI	Sexually-Transmitted Infection
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNRWA	UN Relief and Works Agency for Palestine Refugees
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteers
WHO	World Health Organization

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INTRODUCTION

Until recently, there had been little recognition of the role of mental health in post-conflict reconstruction. As described by Mollica, most aid organizations subscribed to the "rubber band" model of mental health, which assumed that once food, water, shelter, and essential services are provided, individuals will snap back and resume their normal lives (Gewertz 2005). A growing body of research and experience, however, has shown that individuals and communities traumatized by conflict and displacement, experience lasting mental health and psychosocial disorders and they do not easily revert to normal once the violence ends. As a result there is increasing recognition that addressing mental health and psychosocial needs in conflict and post-conflict situations is critical for reducing the likelihood of future conflicts and ensuring effective and sustainable reconstruction. This paper provides an overview of the role of the World Bank in conflict-affected countries; explores the links between conflicts, poverty, mental health and psychosocial consequences; and examines the relationship between mental health, conflicts and social capital. It presents a conceptual framework for psychosocial and mental health interventions, and briefly examines five Bank-supported cases of mental and psychosocial interventions in conflict settings to illustrate possible approaches. It reviews remaining challenges and presents recommendations on the Bank's role in addressing mental health in conflict settings.

BACKGROUND: THE WORLD BANK AND CONFLICT

The World Bank's early involvement in post-conflict reconstruction, dating from the end of World War II, focused on providing financial capital and rebuilding physical infrastructure. However, in a post-Cold War era marked by an increase in the number and severity of intrastate conflicts, the Bank has had to adapt to different and more complex challenges. The Bank's involvement in Bosnia-Herzegovina and in the West Bank and Gaza prompted a re-examination of its broader engagement and mandate in conflict-affected countries. In 1998, mindful of the new challenges, the Bank's Operations and Evaluation Department (OED) took a careful look at the institution's post-conflict performance (World Bank 1998b). Although it found many unanswered questions, and judged that the Bank's performance could be improved in a number of important respects (e.g., greater efforts to rebuild human and social capital), it concluded that the institution had a definite comparative advantage in supporting the special needs of countries emerging from conflict. The Bank realized that it faced more complex challenges, so in 1997 it had created a Post-Conflict Unit in the Social Development Department, defined a framework for Bank engagement in post-conflict reconstruction, and set up the Post-Conflict fund (PCF) to support countries in transition from conflict to sustainable peace and early Bank engagement in conflict-affected countries.

With poverty both a cause and a consequence of conflict, in 2000 the Bank sought to redefine its role more broadly, from an approach focused on physical reconstruction to one focused on the root causes of conflict, to integrate sensitivity to conflict in Bank activities and to promote assistance that minimizes the potential causes of conflict. In line with this shift in focus, in January 2001 the Executive Directors approved Operational Policy 2.30 (OP2.30), *Development Cooperation and Conflict*, which sets the

framework and parameters for engagement in conflict-affected countries. To signal this shift in emphasis, the Post-Conflict Unit was renamed the Conflict Prevention and Reconstruction (CPR) Unit.

OP2.30 sets out three stages of Bank engagement in conflict-affected countries and provides a flexible framework for engagement in countries affected by conflict:

- A Watching Brief may be initiated where normal Bank assistance is no longer possible due to conflict or its aftermath. The Watching Brief allows the Bank to maintain a minimum level of engagement, ranging from monitoring socio-economic conditions to additional grant-financed activities that can be undertaken at the request of the country or the international community.
- A Transitional Support Strategy[1] is a short- to medium term assistance strategy for a country in transition from conflict where a normal Country Assistance Strategy (CAS) is not yet possible.
- A CAS becomes possible as a country successfully transitions out of conflict, and signals a return to normal Bank engagement in the country.

While OP2.30 provides considerable flexibility it also makes it clear that, in line with its mandate, the Bank does not engage in peacemaking or peacekeeping, does not provide direct support for disarming combatants, and does not provide humanitarian relief, all of which are functions assumed by the UN and other agencies or donors. OP2.30 notes the need for partnerships, especially with other bilateral and multilateral agencies, as well as civil society and non-governmental organizations (NGOs) that have complementary mandates and concerns. OP2.30 also notes the need to support social recovery, with particular attention to the needs of war-affected groups who are especially vulnerable because of gender, age, or disability. Addressing mental health and psychosocial needs, with particular attention to vulnerable groups is thus fully in line with the Bank's operational policy on conflict, its mandate and its comparative advantage.

This paper illustrates the links among conflicts, mental health and psychosocial disorders, social capital, human development and poverty. A basic premise of the paper is that understanding and addressing these linkages is important to meeting the Millennium Development Goals, especially those relating to poverty (Goal 1), primary education (Goal 2), empowerment of women (Goal 3), child health (Goal 4), maternal mortality (Goal 5), and HIV/AIDS and other infectious diseases (Goal 6).

GLOBAL EXTENT OF CONFLICT

Since 1980, substantial periods of war have afflicted over 50 countries, and more than 30 wars have plagued Africa since 1970. In its *State of the World's Children 2000*, UNICEF estimates that there has been a 40 percent increase in complex emergencies over the last decade. Moreover, in recent years the face of war has changed in that civilian populations are being targeted with increasing frequency. According to global estimates, in the 20th century 191 million people lost their lives directly or indirectly due to collective violence, and 60 percent of those deaths occurred among people not engaged in

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[1] Under new operational procedures, the Bank's Transitional Support Strategy document will be renamed Interim Support Strategy, but its objectives and content will remain unchanged.

fighting (WHO 2002). The first *World Report on Violence* estimates that, in the year 2000 alone, a total of 310,000 people were killed by war-related causes (WHO 2002).

Conflict related deaths are heavily skewed toward low-income countries. Viewed globally, the above statistic for war-related deaths in 2000 translates into 5.2 deaths for every 100,000 of the world's population. However, when analyzed by income-level (Table 1), the number of war-related deaths was close to zero in high-income countries in 2000, but 6.2 for low-income countries (WHO 2002). In the past 20 years, at least 15 of the world's 20 lowest income countries have been affected by significant armed conflicts. Moreover, almost all low-income countries that have not directly experienced conflict, border conflict or post-conflict countries (Holtzman, Elwan and Scott 1998). Of the 127 wars that have occurred since World War II, 125 have been in low-income countries (De Jong 2002) with 60 percent of all on-going wars since 1999 concentrated in Sub-Saharan Africa (Carballo et al. 2004).

Table 1: **Conflict-Related Deaths by Region**

Region:	Deaths per 100,000
High-Income Countries	0
Low-Income Countries	6.2
WHO Africa Region	32.0
WHO Eastern Mediterranean Region	8.1
WHO European Region	4.2

Source: WHO (2002)

THE IMPACTS OF CONFLICT

The impacts of conflict are complex and wide ranging. They are not confined to countries at war—they ripple outward from the initial violence, spreading from individuals and communities to countries and regions. Conflicts cause widespread insecurity due to forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. This insecurity can persist long after the conflicts have ended as internally displaced persons (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss, and regain a sense of normalcy. Bank research suggests that because these adverse effects persist for a long time, much of the cost of a war occur after it is over (Collier et al. 2003).

IDPS, REFUGEES AND ASYLUM SEEKERS: A GLOBAL OVERVIEW

Over the last 30 years, over 80 million people have been forced to flee their homes, communities, or nations as a result of conflict (Carballo et al. 2004). As of the end of 2003, there were an estimated 38 million uprooted people (13.7 million refugees and 24.5 million IDPs), almost 16 million of whom were in Africa (UNHCR 2004). In recent years 30 countries have had more than 10 percent of their

populations displaced through conflict. In 10 countries, displacement has been over 40 percent. Figure 1 presents worldwide refugee trends between 1993 and 2002 (UNHCR 2004).

Figure 1: Refugee Population by Region of Origin, 1993-2002 (thousands)
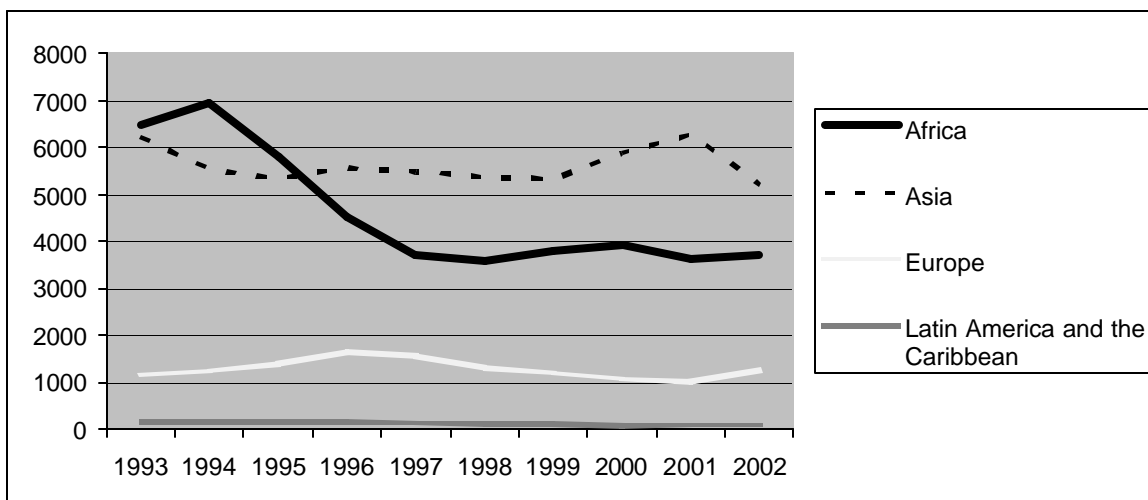
Source: UNHCR (2004).

The influx of refugees and asylum seekers to neighboring countries can lead to destabilization, increased ethnic tensions, strained resources, and damage to the environment. As a result, countries that once allowed displaced people to find refuge within their borders are now less eager to help (De Jong 2002).

BREAKDOWNS IN SERVICE PROVISION: HEALTH, EDUCATION AND HOUSING

Insecurity, violence and displacement lead to the breakdown of social services such as health and education. UNICEF (2000) estimates that approximately 150 million children in Central and Eastern Europe and the former Soviet Union were adversely affected in the early 1990s by the insecurity of the transition period, as illustrated by a sharp increase in mortality rates and resurgence of previously eradicated diseases. Reports indicate that mortality rates for refugee and IDP populations are as much as 50 times higher than the base-line crude death rates recorded for their home communities (De Jong 2002).

Stateless and displaced people are generally unable to engage in productive activities. Often, there are no social safety nets, or those that exist are already overtaxed, so there is nothing to stop those affected by conflict from sliding into poverty or dependence on humanitarian assistance. In this climate, poor families may rely on children's economic contributions or may not be able to afford school fees, keeping children out of school. Conflict, in turn, destroys education systems.[2] A child's education can also be disrupted when there are no teachers, or when there is insecurity or land mine contamination (UNICEF

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[2] For a recent review of the impact of conflict on education systems, see World Bank (2005).

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2004a). The education gaps due to conflict not only affect a country's human capital potential but also opportunities to provide mental health and psychosocial support for children and youth (De Jong 2002).

A recent World Bank study on displacement in Europe and Central Asia (Holtzman and Nezam 2004) indicates that psychosocial factors associated with displacement influence the capacity of displaced populations to move toward self-reliance. The study emphasizes that many problems faced by displaced populations relate directly to the poverty and unemployment created by displacement. Much of the pessimism and demoralization among the displaced come from these factors, but other segments of the population who are also poor are similarly affected. The authors argue for the need to differentiate between psychosocial issues related to the act of displacement and trauma associated with the violence of conflict experienced prior to displacement.

In addition to traumatic war-related experiences and dislocation, displacement leads to conditions where young people may be sleeping in the same room with adults and are thus exposed to sexual activity. Furthermore, in some regions, whole generations have been raised under conditions of armed warfare and may never have experienced peace and stability. Together these factors can lead to increased risk-taking behavior such as alcohol and drug abuse and early sexual contact, often without access to protection from unplanned pregnancies and sexually transmitted infections (STIs). Children and young adults are also at high risk of sexual abuse by relatives or other adults living under the same roof, which can result in the spread of HIV/AIDS, unwanted pregnancies, and/or psychosocial consequences (UNICEF and the Republic of Uganda 1998).

MENTAL AND PSYCHOSOCIAL DISORDERS AND CONFLICT

Among the General Population

Under normal circumstances, 1-3 percent of the population has some form of psychiatric disorder. The psychiatric literature shows that conflict situations increase disorder prevalence (Hoge et al. 2004, Scholte et al. 2004). In addition to conflict-related head injuries, this difference can be explained by the high levels of stress which can serve as a catalyst for the emergence of psychiatric disorders that otherwise might have remained dormant. Furthermore, violent acts such as targeted killings, amputations, gender-based violence, and physical maiming often have long-term psychological effects on those who have experienced or witnessed them. For example, a survey of 750,000 people in East Timor revealed that 40 percent of respondents had been subjected to psychological torture, 33 percent beaten or mauled, 26 percent hit on the head, and 22 percent had witnessed a family member or friend being killed (Zuckerman and Greenberg 2004, p.17). Other forms of conflict-related violence can include forced displacement, restricted movement, forced recruitment, harassment and intimidation, and the dangers posed by landmines and unexploded ordnance. Widespread insecurity and increased poverty, coupled with a lack of basic services such as healthcare, education, housing, water and sanitation, exacerbate mental problems.

Conflict and relocation can have a profound effect on the mental health of affected populations, whether they are refugees, IDPs, asylum seekers or others trying to rebuild their lives and communities. The

transition entails coming to grips with what has occurred and adjusting to life in new environments that may feel foreign and inhospitable. It may also mean impoverishment due to loss of assets and livelihoods, uncertainty regarding the status of loved ones, unemployment and a lack of professional skills suitable for the new location and circumstances. A survey conducted in post-conflict Bosnia and Herzegovina found that over 25 percent of displaced adults stated that they felt they were no longer able to play a useful role in life, and 16 percent had lost all confidence in themselves and their capacity to manage their situation. Eleven percent of the non-displaced also suffered from a "lost sense of personal worth" (Carballo et al. 2004, pp. 6-7).

Mental disorders and psychosocial consequences associated with conflicts include sleeplessness, fear, nervousness, anger, aggressiveness, depression, flashbacks, alcohol and substance abuse, suicide, and domestic and sexual violence. Following a traumatic event, a large proportion of the population may experience nightmares, anxiety, and other stress-related symptoms, although these effects usually decrease in intensity over time. For some, the hopelessness and helplessness associated with persistent insecurity, statelessness and poverty will trigger ephemeral reactions such as those mentioned above. For others, war experiences may lead to Post-Traumatic Stress Disorder (PTSD) and chronic depression. These conditions, in turn, can lead to suicide ideation and attempts, chronic alcohol and drug abuse, interpersonal violence, and other signs of social dysfunction. Studies by Mollica et al. indicate that populations affected by conflict are not only affected by mental health problems, but have associated dysfunction, which can last up to five years after the conflict. This persistent dysfunction is linked to decreased productivity (Mollica et al. 1996), poor nutritional, health and educational outcomes for the children of mothers with these problems, and decreased ability to participate in development efforts. The effects of mental health and psychosocial disorders in conflict-affected populations can be an important constraint in reconstruction and development efforts.

The Global Burden of Disease study estimated that the burden of disease from mental and behavioral disorders such as depression, bipolar disorder, psychosis, schizophrenia, and substance abuse would increase from 12 percent in 1990 (WHO 2001a), to close to 15 percent by 2020 (De Jong 2002). This estimate was based in part on the projection that violent conflicts would shift from the 16th to the 8th leading cause of disease by 2020, and violence would move from 28th to 12th. Psychoses and mood disorders are widespread in conflict-affected societies (Silove, Ekblad and Mollica 2000). Currently, five mental disorders are among the top ten leading causes of disability, and include alcohol abuse, bipolar disorder, schizophrenia, obsessive compulsive disorder and major depression. At present, major depression is the principal cause of disability adjusted life years (DALYS) among working age populations and the greatest overall source of disability in the world (Whiteford et al. 2001).

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

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

between 40 and 70 percent. Epidemiological studies among IDPs and refugees on the Thai-Cambodian border, in Algeria, Ethiopia, Gaza and Uganda indicate that 15 to 53 percent suffer from PTSD as a consequence of conflict. In Uganda, 71 percent reported major depressive disorder, and in Algeria, Cambodia, Ethiopia and Gaza, psychopathology prevalence was 17 percent among non-traumatized against 44 percent for those who had experienced violence. A study of Cambodian refugees by the Harvard Program in Refugee Trauma showed rates of acute depression and PTSD of 68 percent and 37 percent respectively (Mollica et al. 1998, and Mollica 2001), significantly higher than those found among the general population (10 percent and 3 percent respectively). A study of Bosnian refugees in Croatia revealed similarly high rates of depression (14 to 21 percent), and PTSD (18 to 53 percent) (Mollica 2001). Recent epidemiological studies of mental health in communities affected by the war in Afghanistan found high prevalence of symptoms of depression, anxiety and PTSD (Cardozo et al. 2004, Scholte et al. 2004). Nationwide the prevalence of depression was 68 percent, 72 percent for symptoms of anxiety, and 42 percent for PTSD symptoms. Women had significantly poorer mental health status than men, as did the disabled. Feelings of hatred were high at 84 percent. Coping mechanisms included religious and spiritual practices; focusing on basic needs such as 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).

For Ex-combatants

A 2003 study by Hoge et al. on the mental health status of U.S. military personnel surveyed 2,530 soldiers before service in Iraq and Afghanistan and 3,671 who had already served, three to four months after their return. The results indicated that soldiers returning from combat were more likely to have self-reported alcohol abuse problems than troops surveyed pre-deployment. Soldiers serving in Iraq had a significantly higher rate of mental health problems such as depression, anxiety, and PTSD (15.6-17.1 percent) than either soldiers who had yet to deploy (9.3 percent) or those who had served in Afghanistan (11.2 percent). The authors explained the disparity in mental health problems for soldiers in Iraq versus Afghanistan by the significant difference in combat exposure between the two groups. They found that disorder rates were related to "combat experiences, such as being shot at, handling dead bodies, knowing someone who was killed, or killing enemy combatants" and having been "wounded or injured" (Hoge et al. 2003). The results may actually underestimate the impact of conflict on the mental health of soldiers since the authors reported using conservative measures for mental health disorders. Furthermore, past studies suggest that combat-related mental health conditions can increase more than two-fold between initial assessment and follow-up several years later (Friedman 2004).

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 that 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.

Another factor related to the mental health of ex-combatants is their failure to acknowledge mental health problems and seek medical assistance. One study revealed that 28.5 percent of male civilians with mental disorders sought treatment versus only 19 percent of military personnel with comparable disorders (Friedman 2004). According to Hoge and his colleagues, fear of stigmatisation plays a substantial role in soldiers' failure to seek treatment. Concerns included fear that admitting a need for help might harm their careers, reduce peer confidence in their abilities, and be construed as a sign of weakness. Although available data on the mental health of ex-combatants deal almost exclusively with Western populations, their elevated disorder prevalence rates and comparatively high reluctance to seek treatment may also be found in other populations.

CONFLICTS, SOCIAL CAPITAL AND POVERTY

Individual, interpersonal, institutional, and structural factors lead to and perpetuate violence in conflict situations. For example, a political framework that supports discrimination, high rates of unemployment, easy access to gangs, and limited options for personal advancement may interact to create an environment that readily supports violence. These relationships are highlighted in Figure 2 (adapted from Moser and Shrader 1999). The links between each level must be acknowledged when attempting to understand the roots of conflict.

Social capital refers to the norms and networks that enable collective action. Based largely on trust between parties, it allows individuals, communities and nations to reach their shared objectives. Social capital exists at all levels of society and can be used as a "bridging" mechanism to bring groups together, or as a "bonding" mechanism to strengthen the ties between members of an existing group (Colletta and

Cullen 2000)—also referred to as "the glue that holds societies together" (Dasgupta and Serageldin 2000).

Positive social capital affects economic wellbeing at different levels. At the national level, social capital has been shown to impact economic performance (Knack 1999), while at the individual and community levels social capital improves household welfare beyond the levels of physical assets or education (Narayan and Pritchett 1997). Households rich in social capital are more successful in accumulating material goods and savings and are better able to obtain credit (Grootaert 1999). Social and economic impacts are greatest when social capital is used as a bridging mechanism to strengthen the relationships between groups (Narayan and Cassidy 2001). In post conflict Guatemala, for example, social capital helped sustain peace efforts by bringing diverse women's groups together, allowing for the development of inclusive ties and collective action (Colletta and Cullen 2000).

Figure 2: Integrated Model for Violence Causality Applied to Conflict Situations

Structural

Institutional

Interpersonal

Individual

Macro level political, economic, and social structure and policy environment, including the opinions, beliefs and cultural norms that permeate society (i.e. ethnicism, legitimization of

Poor or no school system, presence of gangs in the community, lack of employment opportunities, lack of skills required for employment, little to no positive social capital, opportunity to join rebels

Family member involved in the conflict, dysfunctional or violent family, delinquent peer associations

Low self esteem, desire for status or revenge, greed, poverty

Source: adapted from Moser and Shrader (1999).

Conflict destroys positive social capital. Once conflict erupts, it undermines interpersonal and communal trust, destroys the norms and values that underpin cooperation and collective action, and diminishes the capacity of communities to manage conflict without resorting to violence. The outbreak of conflict, in turn, tends to generate increased forms of negative social capital, as affected communities strengthen intergroup bonds as a way of coping with external threats from the state, rebel forces or opposed groups, at the expense of intragroup relations and trust. This undermines the ability of the state and other

structures in society that would normally mediate social conflict. As social capital declines, cooperation within communities, and even within households, suffers and productive capabilities are compromised (Moser and Shrader 1999). Likewise, social capital in the form of strong bonds within groups can serve as a tool for violence as parties lose trust in each other and their cooperation declines (Whiteford et al. 2003). In Rwanda and Burundi, for instance, social capital was used to bond Hutu, which in turn powered the genocide. The Hutu went so far as to broadcast the names of ethnic group members who had not partaken in the genocide, to pressure them into participating (Colletta and Cullen 2000). Social capital has the potential to fuel wars or to facilitate the reconstruction of post-war societies. Once conflict ends, even if other forms of capital (human, financial, or physical) can be replenished, sustainable development will be constrained unless positive social capital can also be rebuilt.

MENTAL HEALTH AND SOCIAL CAPITAL

Mental health problems affect the ability of societies to generate positive social capital. For the last 20 years, if mental health was addressed at all in post-conflict situations (or development efforts more broadly)[4], interventions focused solely on serious mental illnesses. Because serious mental illness affects a relatively small number of people, generally it was not considered a priority in post-conflict reconstruction and recovery. Although the mental effects of trauma and conflict on affected populations have long been recognized, it was implicitly assumed that in post-conflict developing countries these effects would be temporary and would recede with a return to normalcy. With a growing interest in understanding the role of social capital in post-conflict reconstruction, and the need to focus on mental and psychosocial health in populations emerging from conflict, there is also increasing awareness of the links between social capital and mental health.

An inherent attribute of social capital is active community participation for collective action. If a mental illness prevents individuals from participating 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. It can thus be hypothesized that, as a development objective, investing in mental wellbeing among post-conflict populations contributes to strengthening social capital. Building social capital, furthermore, can be an effective means of preventing future mental disorders (De Jong 2002).

In conflict-affected households, mental health conditions can lead to low levels of social capital, which in turn exacerbate mental health problems. Within families, males may experience depression, anxiety, and psychosomatic illnesses from their war-experiences due to memories of atrocities they witnessed or performed, guilt over not being able to protect their families adequately, or because of sudden unemployment and a lost sense of purpose. These effects, in turn, may be manifested as hostility toward family members. A study on crime and violence in Colombia by Moser and McIlwaine showed that male unemployment and the loss of status as the family provider is associated with drug and alcohol

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[4] For a general discussion of the links between socio-emotional wellbeing and development, see Affolter (2004).

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abuse, and increased domestic violence (quoted in Correia 2003). During and after conflicts, women often find themselves having to deal with violence from or loss of men in their families, while taking on the new and stressful role of sole provider, often in new and insecure environments. The resulting deterioration of household social capital increases women's chances of suffering from mental disorders. Children within the household who have witnessed the apparent powerlessness of their parents in conflict situations and are affected by weakened parental and social support, may be left with a lack of respect for their elders and little hope for the future.

Mental disorders are disabling. Mental disorders following conflict lead to dysfunction. Dysfunction, in turn, increases the risk of poverty, and poverty leads to a sense of hopelessness and helplessness. The Bank's *Voices of the Poor Study* demonstrates a clear link between poverty and mental distress (Narayan et al. 2000).

WHO's new International Classification of Functioning and Disability (ICF) provides a multi-perspective approach to the classification of these components. It recognizes that social participation and activity are influenced by disease and disorder, environmental factors such as conflicts, levels of social capital, and personal factors such as personality and economic status. Figure 3 presents a conflict-focused adaptation of ICF, showing the interrelationships between conflicts, poverty, mental and psychosocial disorders and social capital.

Figure 3: The Interrelationships of Conflicts, Mental Disorders, Dysfunction and Social Capital
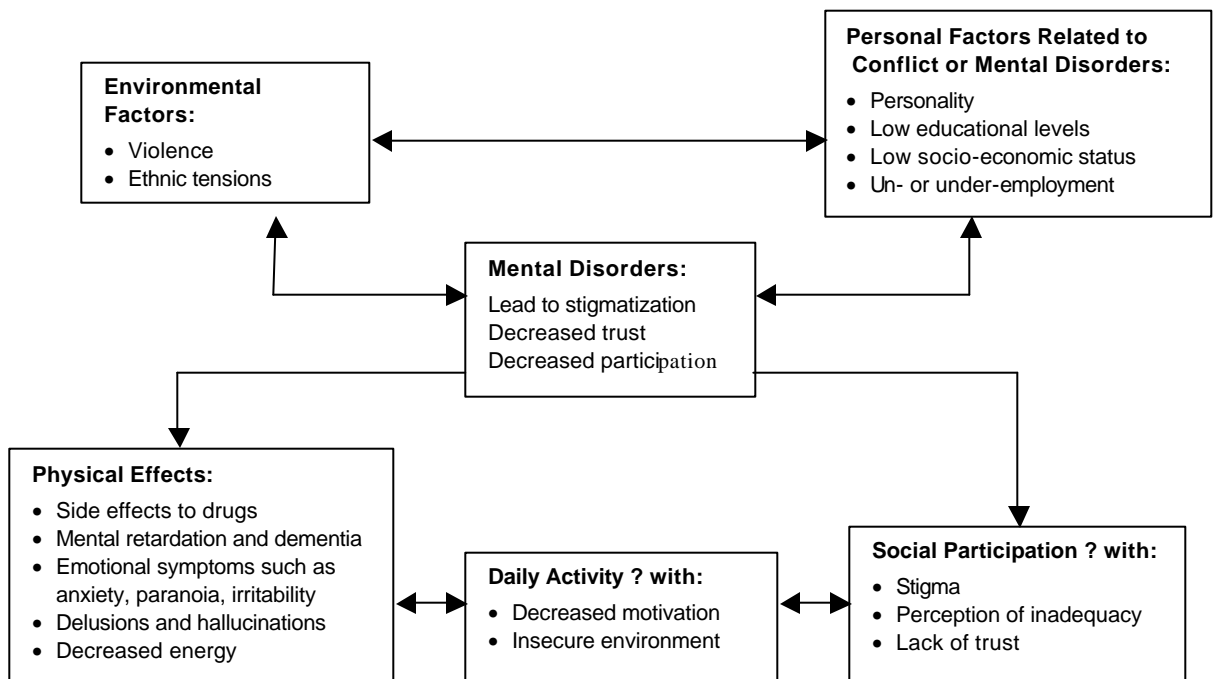
GENDER AND CONFLICTS

A number of studies have shown that women are two times more likely than men to experience PTSD (Kessler et al. 1995). Studies of Bhutanese refugees in Nepal support this finding, showing that tortured and non-tortured women had more disorders, respectively, than tortured and non-tortured men (Van Ommeren 2000). Research by Cardozo et al. (2004) in Afghanistan also shows significantly poorer mental health among women than men. In general, women tend to suffer from mood and anxiety disorders more frequently than men and are also more likely to be poor, oppressed and forced into positions of submission. These factors place them at heightened risk for chronic emotional problems. Gender-related aspects of conflict include child soldiers, women ex-combatants, victims of gender-based violence, the special needs and cultural attitudes toward widows, and culturally-appropriate ways of treating and seeking the views of women in the community (Bouta, Frerks and Bannon 2004).

Although 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 child soldiers are always boys. 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. Those who resist may be beaten, disfigured, or killed. Girls who do manage to escape from their captors often face stigmatization and estrangement from their families, and many are left with STIs and children of their own as a result of repeated sexual abuse (Bouta, Frerks and Bannon 2004).

Studies have also shown that, in some instances, women who participate in the fighting are more likely to experience symptoms of mental distress than men. One explanation for this disparity is the additional stress of sexual assault and harassment, which varies in severity depending on environment and culture (Engdahl et al. 2003). American females who served in the first Persian Gulf War, for example, were three times more likely than their male counterparts to suffer from PTSD (Wolf, Sharkansky and Reed 1998).

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 (Narayan et al. 2000). 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.

CHILDREN AND CONFLICTS

Among conflict-affected populations, children are the most vulnerable. Armed conflict alters their lives in direct and indirect ways, and in addition to the risk of being killed or injured, they can be orphaned, abducted, subjected to sexual violence or left with deep emotional scars and psychosocial trauma from direct exposure to violence, dislocation, poverty and the loss of loved ones (UNICEF 2004). Landmines pose a particular threat to children—over 80 percent of landmine victims are civilians and nearly one third of these are children (UNICEF 2004). In the last decade, more than 2 million children

have died, more than 6 million have been permanently disabled or seriously injured, more than 1 million have become orphans, and more than 12 million have fled their homes (UNICEF 2004a). The effects of conflict on children do not end when the conflict ends. Recent research finds that in a typical five-year war, infant mortality increases by 13 percent during the conflict, but the effect is persistent—in the first five years post-conflict, infant mortality rate remains 11 percent higher than the baseline rate (Collier et al. 2003).

Due to their sensitive, developing neurological systems, children are more susceptible to shocks to their developmental process than adults. These shocks may include direct traumatic events (i.e., in Burundi where a child survived a machete blow to the head but is left with epilepsy and mental retardation), or more subtle shocks such as chronic, severe malnutrition leading to stunting and cognitive impairments (i.e., seizure disorders and retardation). A study by the University of the Philippines covering 1,200 children in Mindanao found that 94 percent manifested trauma symptoms, of which 12 percent were severely traumatized, including the 2.8 percent who were torture victims (Margallo 2004). Children born after troubled pregnancies also have a substantial risk of long-term mental retardation if "reared under adverse social conditions" like those resulting from conflict (De Jong 2002). They are also at increased risk of birth injuries and communicable diseases that affect the brain (Silove et al. 2000).

In conflict situations, mothers may be depressed or suffer from PTSD and thus be unable to provide the necessary stimulation for their young children. It also may be that children who are chronically hungry are lethargic and not receptive to being motivated by mothers. In addition, stress in the environment can lead to stress and domestic violence at home. This may be partner violence that children observe, or it may be directed at children by their parents.

Due to the breakdown of health care services in conflict-affected regions, women often have no access to contraception, antenatal care or perinatal services, placing both women and children at risk. Lack of safe water and sewerage systems increase child susceptibility to diarrhea, while the overcrowding which takes place in refugee camps puts children at risk of respiratory tract infections and contagious diseases. Disrupted infrastructure and insecurity also reduce access to regular immunization, increasing the likelihood of epidemics.[5] The combination of these factors leads to very high infant and child mortality rates, especially among refugees and internally displaced populations. The resulting child deaths lead to further trauma for parents and siblings.

Conflicts devastate education systems, severely impacting human capital and the next generation. The Northern Uganda Psychosocial Needs Assessment (NUPSNA) found that conflict-affected children were not able to go to school or, if they did, the service was very poor. Many teachers were killed or had fled from conflict-affected areas and, for some populations, insecurity made it impossible for the students to get to schools. For others, the parents were not working and so were not able to afford school fees. In some areas, the populations of as many as three schools were crowded into one site, making class size enormous. In others, the students went to school late, waiting to ensure that it was safe, then returned home early before the conflict resumed. Some reported attending only two hours of

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[5] For a recent analysis of the health effects of conflict on children, see Bustreo et al. (2005, forthcoming)

school per day. Those who did attend had no access to textbooks and were unable to study in the evenings for reasons related to the conflict.

In Uganda, the above conditions led to a high level of school dropouts or students who were not able to pass the state exams. Young men manifested high anti-social behavior, often joining gangs, using alcohol, and committing petty crimes. Young girls saw marriage as the only possible alternative to their conditions and often married much older men who could provide for them and their families. Some young girls reported feeling redundant and engaging in sexual activity with their male peers, leading to out-of-wedlock pregnancies.

In addition to displacement, increased malnutrition, destabilized families, and disrupted education, children face the risk of forced military service. During wars children are abducted, subjected to torture or forced to watch the abuse of friends and family members, forced into service as soldiers, and commanded to perform atrocities. In Mozambique and Northern Uganda, children forced into military service were made to kill a parent or member of their community to ensure loyalty, since they could then never return home (De Jong 2002). In May 2000, one quarter of the troops fighting for the Sierra Leonean Government were under 18 years of age.[6]

USAID has led efforts to better define vulnerable children. This has been integrated into the Orphans and Vulnerable Children (OVC) work of the World Bank. A framework adapted from that proposed by Anne Kielland is presented in Table 2.

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[6] On child soldiers, see Verthey (2001).

Table 2: An OVC Taxonomy: Conflicts and Mental and Psychosocial Disorders Perspective

	AIDS Affected	Conflict Affected	Street Children	Children in Worst Forms of Labor	Disabled Children
Orphaned Children	▪ Evidence of increased spread of HIV with armed forces ▪ Orphaned children more susceptible to HIV/AIDS ▪ Many parts of Africa have double burden of HIV/ AIDS and conflicts	▪ War orphans are more vulnerable to abuse, to lack education, lack access to health services	▪ Some of the street children are orphans ▪ In rural areas, they wan ▪ 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 disabilities, amputees e.g. in Sierra Leone ▪ Poor health services may lead to polio, epilepsy, cerebral palsy, or mental retardation
Children Separated from Parents	▪ Breakdown of social support systems during conflicts will lead to AIDS orphans not getting support from the community	▪ Displaced and unaccompanied refugees ▪ Increase in the numbers of child headed households	▪ Children separated from parents as a consequence of conflicts are at risk of ending up on the streets	▪ 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.
Children Living with Dysfunctional Parents		▪ 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 the children who will in turn end up on the streets	▪ Children running away from dysfunctional homes are easy prey for the army	▪ Children living with dysfunctional parents are at risk for emotional disorders of childhood
Children with Needs Beyond Parental Care	▪ Not possible to have PMCT initiatives in conflict situations ▪ Children born with HIV during situations of conflict	▪ Ex-child soldiers ▪ Ex-abductees	▪ Children who may be abusing drugs ▪ Those in conflict with the law ▪ Female ex-abductees with children	▪ Child soldiers ▪ Abductees still under the control of the rebels ▪ Girls forced to marry rebels	▪ Amputees ▪ Mine affected

APPROACHES TO ADDRESSING POST-CONFLICT MENTAL HEALTH

APPLYING WESTERN APPROACHES IN DEVELOPING COUNTRIES

Although a number of approaches have been used in developed countries to deal with post-conflict situations, most are not readily applicable to the conditions found in developing countries. This is in part due to the large disparity between mental health resources in the West versus the rest of the world. For example, while Europe has 8.7 psychiatric beds per 10,000 population, Africa and South-East Asia have only 0.34 and 0.33 beds per 10,000, respectively. The variance among regions is also great with regard to mental health personnel. Europe has 9.0 psychiatrists per 100,000 population, whereas Africa (0.05), the Western Pacific (0.28) and the Americas (1.6) have dramatically fewer psychiatrists to meet their needs (WHO 2001b). Even when there are trained professionals equipped to handle mental health problems, many are forced to flee, or murdered, as a result of the conflict. Moreover, most resources available for mental health in developing nations are concentrated in large, urban institutions and are not accessible to the majority of the population. In nations that do have mental health professionals, they may be unwilling to travel to remote areas due to safety concerns and, even when they do, may not be able to relate to rural populations (De Jong 2002).

The critical need for intervention coupled with the dilemma of limited resources led the 1974 WHO Committee on Mental Health to conclude that, in order for basic mental health care to reach the populations of developing countries, such care should be provided by non-specialized personnel at all levels of the health care system. This is especially true under conflict and post-conflict conditions where mental health needs are widespread.

In addition to the basic differences in available resources between developed and developing countries, Western models themselves may be at odds with the experiences, cultures and needs of most non-Western societies. In order to plan effective interventions, the way that distress and suffering are conceived and manifested in diverse societies must be understood (Loughry and Eyber 2003). Psychiatric categories that are used in the West may not translate to other parts of the world, and perceptions of time, traumatic experience, and the emotional distress related to the disruption of social relations and rituals may vary dramatically (Igreja et al. 2004). Even measurement instruments constructed specifically for developing countries may not be applicable across cultures. For example, the Harvard Trauma Questionnaire (HTQ) categorizes "lack of shelter" as an indicator of trauma. While Mollica et al. found this to be accurate for Indochinese refugees, it was not the case for the sample population in Igreja et al.'s study in Mozambique (Igreja et al. 2004), where the type of shelter mattered.

THE POSITIVE ROLE OF TRADITIONAL APPROACHES AND BELIEFS

The way traumatic events are socially viewed can dramatically impact how they are dealt with emotionally. For example, family members of Albanian Kosovars who died in the 1999 war viewed their loved ones as martyrs, which helped ease the grieving process (De Jong 2002). Similarly, cultures with a strong belief in an afterlife or reincarnation may experience a lower level of trauma when accepting the deaths of loved ones. Two recent studies conducted in Afghanistan demonstrate the substantial role values and beliefs play in coping with loss and facing the future. Lopes Cardozo and his colleagues (2004) found that 'reading the Koran or praying' was among the top two coping strategies employed by disabled and non-disabled Afghans. Likewise, Scholte et al. (2004) reported that religion and family were the most frequently cited sources of emotional support for Afghans. A study by Punamaki (1996) on the mental health of Palestinians found that ideological and religious commitment, social connectedness, and local political involvement were all contributing factors to improved mental health among women and their children.

The majority of people suffering from mental health disorders in developing countries do not seek treatment in health facilities at any level. Instead, those who do seek help often resort to traditional healers and rituals. As a consequence of their easy accessibility and cultural acceptability, traditional healers have the potential to become important resources for mental health care. As Mollica points out, despite the devastation caused by conflict or other traumatic emergencies "…the local healing system is still there, no matter how damaged…" acting, in effect, as "psychological first aid" (Gewertz 2005, p. 3). However, incorporating traditional healers and rituals in the healing process must be approached cautiously since the same high social regard that can make them effective can easily be abused.

Communities' own rituals and traditional practices can often help people affected by trauma reintegrate 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. These rituals contrast with Western (and more intrusive) modes of dealing with trauma, which emphasize psychotherapeutic recounting and remembering experiences. Instead, traditional rituals aim to create a rupture with the past (McKay and Mazurana, p. 48). For example, while in some societies raped women are blamed for bringing dishonor to their families and are ostracized or murdered, in Uganda, a "collective purification ritual" conducted by elders has been shown to help survivors of group rape deal with their traumatic experience (De Jong 2002). Communities in Angola and Mozambique practice special rituals and ceremonies to help soldiers make the transition to peace and reintegration (Honwana 1997, Wessels and Monteiro 2000). Efforts should be made to determine existing practices that facilitate trauma recovery, and to compile evidence as to whether or not they positively impact mental and psychosocial conditions, and strengthen those practices that work.

While rituals and cleansing ceremonies can be very helpful in dealing with milder forms of psychosocial stress, and in assisting communities in coping with returnees from conflict, they

should be approached with caution. McKay and Mazurana note the need for caution from a gender perspective, since "some rituals violate the human rights of women and girls, reinforce patriarchy and oppressive gender roles…" (McKay and Mazurana 2004, p. 50). In some instances, rituals may be clearly damaging, as for example when they involve female genital mutilation performed by members of secret societies (Bouta, Frerks and Bannon 2004). Just as useful approaches should be encouraged, efforts must be made to discourage customs detrimental to mental and psychosocial wellbeing.

DIAGNOSING MENTAL DISORDERS IN POST-CONFLICT SETTINGS

Considering the role of culture, it is not surprising that instruments used to diagnose mental and psychosocial disorders in the West may not be applicable to the developing world. Consequently, efforts must be made to understand how individuals and societies conceptualize trauma and manifest their distress so that culturally relevant tools can be developed.

One important consideration in measuring the prevalence and severity of mental and psychosocial disorders in conflict-affected areas involves differentiating between symptoms of mental disorder versus normal reactions to intensely abnormal events. This question underscores the need for early psychosocial programs that provide services to conflict-affected populations. Once psychosocial programs are in place and communities have begun the healing process, it may be easier to identify cases of more severe mental disorder requiring more specialized treatment.

Misclassification of mental and psychosocial disorders can also be a problem when physical ailments obscure the psychological roots of the problem. Studies have shown that some health complaints are actually manifestations of mental distress that go unrecognized by primary care physicians. In Goa, India, for example, Patel and Oomman (1999) found that resources were being wasted when the syndromic approach to managing STIs was used to treat women attending outpatient gynecological clinics. Up to 60 percent of women complaining of discharges and lower abdominal pain actually tested negative for gynecological disorders and positive for mental disorders. It has also been found that up to 40 percent of patients who attend general outpatient departments are treated for vague aches and pains when in fact they have common mental disorders such as depression or anxiety.

There has been some success in adapting Western diagnostic tools to diverse cultures affected by conflict, and validating them within these environments. Mollica et al. (1992) developed and validated three versions of the Harvard Trauma Questionnaire (HTQ) to capture trauma symptoms associated with PTSD for Indochinese refugees. Likewise, the Burundi Institute for Economic and Statistical Studies (ISTEEBU) included 12 mental health questions in the 1998 national Burundi Priority Survey, which were modified from the General Health Questionnaire (GHQ-12) used worldwide to gauge mental distress (Baingana et al. 2004). Psychologists and psychiatrists from the University of Burundi adapted the questions to suit the Burundi context.

While this may have affected the direct comparability of the results to other GHQ-12 studies, it ensured that the instrument was appropriate for use within Burundi. The approach followed in Burundi suggests that local experts can adapt Western tools to their own realities, with input from local psychiatrists and psychologists to define the correlations.

The results of the Burundi Priority Survey were used in the Bank's Economic and Sector Work to better understand the links between mental health and psychosocial wellbeing. The *Burundi Poverty and Vulnerability: Interim Report* (World Bank 2004) includes a section on the impact of the conflict on psychological health, disaggregated by quintiles, and provides a good illustration of an approach to documenting the need for psychosocial interventions.[7]

THE IMPACT OF MENTAL AND PSYCHOSOCIAL INTERVENTIONS

There is a general lack of evidence supporting the effectiveness of psychosocial and mental health interventions in conflict-affected regions (Bolton and Betancourt 2003). This dearth of information is not entirely surprising when the vast needs of conflict-affected populations are viewed relative to the limited resources available. However, limited funding and resources are the reason why determining effectiveness is critical. This, coupled with the possibility that misdirected interventions can do more harm than good, are reasons to address the lack of data and systematic evaluation.

Bolton and Betancourt (2003) suggest that limiting short-term mental health interventions to a specific proportion of conflict-affected populations can be a useful approach to determining intervention success. If the evaluation is positive, the intervention can be scaled up. If the intervention is not successful or is shown to be detrimental, the costs and negative effects of its application to the wider community can be avoided. The 2003 Uganda study by Bolton et al. (2003) is an example of this approach and provided the rationale for using interpersonal psychotherapy to treat depression and dysfunction in post-conflict Uganda. Programs with and without psychosocial components should also be compared to gauge their effectiveness in meeting the unique post-conflict needs of distinct cultures and communities. Controlled trials of psychosocial interventions are lacking.

Although concrete studies are still needed in this area, the benefits of interventions to address mental and psychosocial disorders 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,

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[7] A sub-sample of respondents aged 10-65 years were asked a series of questions designed to assess psychosocial health—whether the person has had nightmares, whether he/she is scared, feels useful, resourceful, is sad, feels strong, feels angry, makes plans for the future, and more generally has been affected by the crisis. The report found an inverted-U relationship between economic status and the impact of the conflict on people's mental health. Many of the mental health indicators were worse for the bottom quintiles, although some indicators were also bad for the richest quintile.

feelings of worthlessness and hopelessness, depression, anxiety, suicide ideation, alcoholism. At the community level, they may include increases in inter-personal violence, teenage pregnancies, school dropouts, 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 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.

PSYCHOSOCIAL OPPORTUNITIES FOR REFUGEES AND EX-COMBATANTS

As previously indicated, the conditions of insecurity and overcrowding associated with refugee camps are detrimental to the health of refugee populations. In addition to deficits in potable water, poor sanitation, and the continued risk of violence, refugee communities face increased risks of STIs due to broken families, disrupted traditions, and the poverty-driven commercial sex trade (Msuya 1996). In many camps there is a "lack of employment for men which leads to boredom, depression and an increase in alcohol consumption" and consequently, "increased domestic violence and rape" (Benjamin 1996). This further fuels the spread of STIs. Addressing psychosocial issues such as the depression and drinking related to lack of employment, perceptions of lost culture, and feelings of social isolation and hopelessness, will serve the dual purpose of improving mental health and reducing the spread of STIs.

In addition to their risks, refugee camps provide a base for interventions that address these needs. For example, CARE International's AIDS Control and Prevention Program (AIDSCAP), at the Benaco camp for Rwandan refugees, offered a wide range of interventions that included AIDS awareness raising, treatment provision, and sexual behavior modification campaigns. At the same time, AIDSCAP's interventions also targeted the association between psychosocial issues and the spread of HIV/AIDS within the refugee community. Approaches included implementing women's income-generation projects to decrease their vulnerability to infection, involving political and religious leaders in planning in order to gain their influential support, organizing tours of health clinics for youth to demystify treatment options, and forming

groups of volunteers to provide support for infected and disabled community members (Benjamin 1996).

Similarly, post-conflict situations offer the opportunity for psychosocial support and HIV/AIDS interventions for armed groups before they are demobilized. The mobilization of armies has been linked to an increase in the prevalence of HIV/AIDS, such as in the Ugandan military where the prevalence rate is much higher among soldiers (27 percent) than for the general population (9.5 percent) (UNAIDS/WHO 2002). Once conflicts cease, infected soldiers return home, passing the virus on to their wives and future children. Thailand's experience has shown that AIDS interventions targeting military populations can be effective in reducing AIDS prevalence and risky behavior. According to a 1997 report, "the percentage of military conscripts in northern Thailand who visited a brothel in the past year fell from 58 percent in 1991 to 23 percent in 1995, while the percentage of recruits using condoms during their most recent brothel visits increased from 60 percent to 90 percent over the same period" (AIDS Weekly Plus 1997). HIV prevalence among military recruits decreased by one third between 1993 and 1995.

For ex-combatants and refugees in countries such as Burundi, Rwanda and Sudan, HIV/AIDS education campaigns such as those used in Thailand must be coupled with socio-economic interventions that contribute to the economic viability of reintegrating populations e.g., vocational training, access to credit, agricultural inputs and other reintegration packages. Above all, people who have experienced mass violence and conflict need to work and earn a living. According to Mollica (2003), the best anti-depressant is a job. He asserts that the immediate post-conflict phase is the ideal time to contribute to the reconstruction process by creating opportunities for employment. Job creation cannot wait five years for factories to be built, since by then dependency has set in and irreversible economic, physical, and mental damage has been done.

A CONCEPTUAL FRAMEWORK FOR MENTAL HEALTH PROGRAMS IN CONFLICT AND POST-CONFLICT COUNTRIES

Recognizing the significance of the linkages among poverty, conflict, social capital, and mental and psychosocial wellbeing is not enough. Although many researchers and this paper posit that psychosocial interventions can contribute to peace, reconciliation and the rebuilding of social capital, it is also important to demonstrate that there are interventions that can reverse the mental and psychosocial dysfunction, that they are feasible and cost-effective in post-conflict environments, and that they will demonstrably lead to increased productivity for the target beneficiaries.

The following section presents a conceptual framework for mental health and psychosocial programming within conflict-affected settings. It highlights several dimensions that must be taken into account in developing effective interventions, including appropriate roles for stakeholders,

levels of mental and psychosocial care, the management of available resources, multi-sector approaches, essential program components and the role of donors.

A number of stakeholders have roles to play in the planning and implementation of mental health and psychosocial interventions, including governments, UN Agencies, international and national NGOs, CBOs and faith-based organizations, and the donor community. A Coordinating Group composed of stakeholders and headed by one of the government branches (i.e., Ministry of Health, Education, Social Protection) should be formed to determine a strategy for mental health and psychosocial programming. They must take into account regional needs, available resources, and comparative advantages in the division of tasks. Communities themselves should be involved in identifying those most vulnerable and most in need, as well as those for whom interventions can be delivered easily and will have the biggest impact. Baseline data should be gathered in order to facilitate these decisions.

Primary, secondary and tertiary levels of care and the benefits and costs of interventions at each level must also be considered in determining appropriate mental health and psychosocial programming. As Figure 4 indicates, conflicts have a broad impact on mental and psychosocial health.

Figure 4: The Relationship between Mental and Psychosocial Disorders in Post-Conflict Settings

In every population, 1-3% have a psychiatric disorder. In conflict situations, the number may increase due to PTSD, alcoholism, drug abuse and depression due to persistent stress. This % is made up of people with a psychiatric diagnosis (e.g., PTSD, depression, schizophrenia) or symptoms such as suicide and baseline mental disorders found in any population

For another group, maybe 30-40%, symptoms mentioned below, such as sleeplessness, irritability, hopelessness and hypervigilance persist and become more severe, interfering with daily life of individuals. This group is not classified as having a psychiatric disorder but may have psychosocial disorders evidenced by domestic violence, crime, school drop out, etc.

A big part of the population may suffer anxiety, nightmares, easy irritability, etc. in the first days or weeks after a traumatic event. These symptoms are often transient and will decrease in frequency over time

Although up to 80 percent of conflict-affected populations may be affected by mental and psychosocial disorders, the scope and coverage of interventions invariably will be limited by resource and capacity constraints, as well as by 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. Poor, conflict-affected countries face a dilemma—whether to

allocate scarce resources to improve institution-based care for the most severely ill, or channel additional resources to support community-based efforts. Ideally, policies, approaches and resources should do both. Figure 5 shows typical resource allocation patterns compared to the mental and psychosocial disorder burden associated with conflict in order to illustrate the inadequacy of current allocation approaches. Resources should be reallocated to more closely match the specific mental and psychosocial needs of conflict-affected populations.

Figure 5: Allocation of Resources
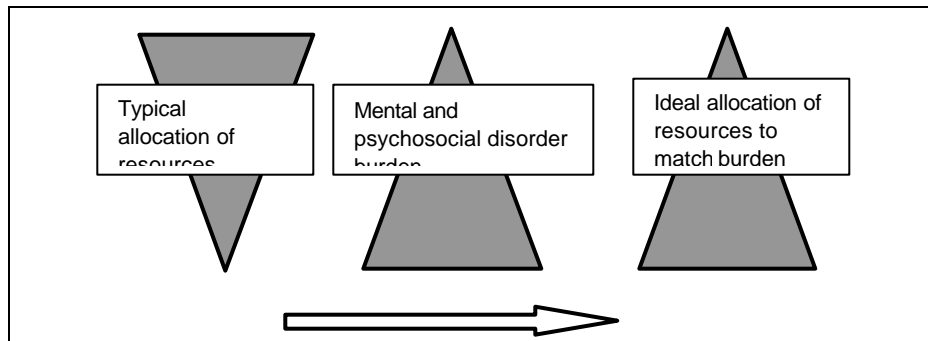
Taking into account the multi-faceted nature of mental and psychosocial disorders, interventions need to be developed with the collaboration and coordination of different sectors. Ideally, mental health and psychosocial interventions should be linked across key human development sectors and throughout relevant government structures, although this is a substantial undertaking that must be pursued gradually. Critical sectors include health, education, social protection, and local administration. Interventions within the education sector, for instance, can be aimed at training teachers to recognize children that may be distressed, provide initial interventions, and refer those that require specialized attention to the appropriate sources. These measures can have a substantial impact on child mental health. Teachers will also need training in how to handle children that may have participated in conflicts, such as child soldiers, since they would react differently to authority. Schools also offer an excellent opportunity for breaking the cycle of violence by integrating peace and reconciliation into the curricula.

Another sector that has a vital role to play in mental health and psychosocial programming is that of social protection (or social affairs), which often addresses issues that affect women and children. This may include special programs that target victims of the sexual violence, often associated with conflict, as happened in Sierra Leone (Physicians for Human Rights 2002), or that address situations where women are severely discriminated against, such as in Afghanistan (Physicians for Human Rights 2001). The social protection sector often has the role of planning and programming for orphans and vulnerable children. This may include tracing and resettlement, which frequently involves a psychosocial component. These initiatives may be carried out in collaboration with NGOs and the local governments, as illustrated in the case of Uganda (discussed later in this paper).
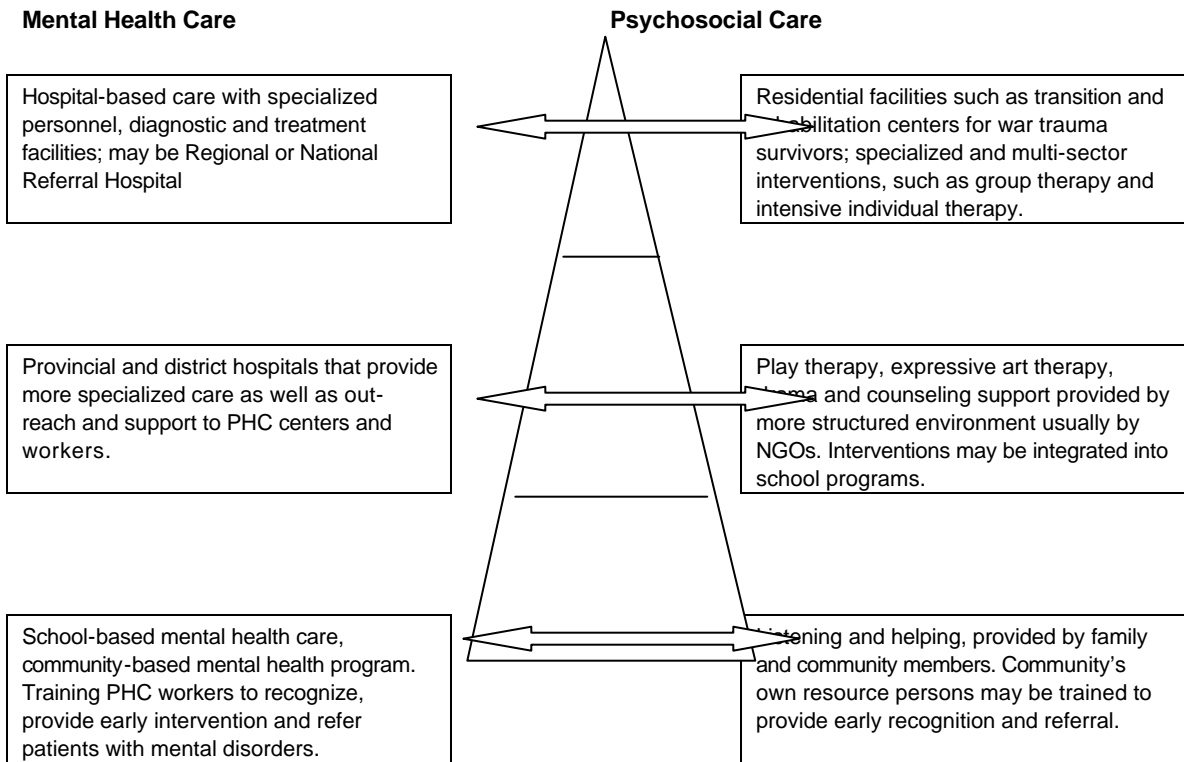
For interventions within each of these sectors, stakeholders and levels of care must be considered, and essential program components developed and implemented. Components include policy and standards, training, support supervision, the coordination of services, referral systems, and methods for monitoring and evaluation.

Another dimension is that of donors and the role they play in determining where resources are allocated. In most post-conflict countries, bilateral and multilateral agencies play a significant role in determining what programs are to be funded and at what levels the implementation will take place. For many post-conflict countries, the initial focus may be on rehabilitation of institutions and infrastructure. For mental health, this often contributes to a focus on funding at the tertiary level with minimal amounts going to the primary care level. For example, in Sierra Leone, the Islamic Development Bank is supporting the rehabilitation of the psychiatric hospital, yet there are no mental health services outside the capital city. In many conflict and post-conflict regions, such as Afghanistan, Burundi, Iraq, Sierra Leone and the West Bank and Gaza, psychiatric institutions are dilapidated. Before investing in their rehabilitation, it would be best for the countries to articulate a longer-term strategy for development of the health sector, including the role of community mental health services as well as their integration into primary health care.

It is important to keep in mind that for some countries, mental health and psychosocial interventions may begin small scale, in one or two regions or focusing on one layer of the mental health system, gradually scaling up as experience and lessons emerge. It may also be necessary to begin in one sector, the one that is most ready (e.g., education), and then gradually expand to cover other sectors (e.g., health, social protection). While an integrated and coordinated intervention effort is the ultimate goal, for most developing post-conflict countries this is likely to be achieved in stages.

Figure 6 provides a framework for services addressing the three levels of mental and psychosocial disorders—mild, moderate and severe. There is a need to ensure complementarity in the provision of these services at the primary, secondary and tertiary levels, as well as referral both up and down the system. Even successful community- or school-based psychosocial interventions need to be able to refer the more serious mental health cases to higher levels in the mental health care system. In turn, just as the effectiveness of the mental health system is greatly improved by having an efficient referral system from the community and schools, it also benefits when less severe cases can be referred down to lower levels. In reality, it may not be as effective to establish a mental health program without the availability of psychosocial services and vice versa since each of the levels of care is crucial to the successful implementation of the interventions.

Figure 6: Relationship Between Mental Health Care and Psychosocial Services

Mental Health Care   **Psychosocial Care**

| Hospital-based care with specialized personnel, diagnostic and treatment facilities; may be Regional or National Referral Hospital |

| Residential facilities such as transition and rehabilitation centers for war trauma survivors; specialized and multi-sector interventions, such as group therapy and intensive individual therapy. |

| Provincial and district hospitals that provide more specialized care as well as out-reach and support to PHC centers and workers. |

| Play therapy, expressive art therapy, drama and counseling support provided by more structured environment usually by NGOs. Interventions may be integrated into school programs. |

| School-based mental health care, community-based mental health program. Training PHC workers to recognize, provide early intervention and refer patients with mental disorders. |

| Listening and helping, provided by family and community members. Community's own resource persons may be trained to provide early recognition and referral. |

There are no studies that assess the effectiveness of psychosocial interventions, and few for mental health care in the developing world, let alone for populations affected by conflict. Figure 6 represents current best practice for populations affected by conflict based on the experiences of NGOs and agencies working in the psychosocial and mental health fields. The need for cost-effectiveness studies for such interventions is becoming increasingly apparent and some agencies have begun to do this work. The World Bank's CPR Unit supported a study on "Cost–effective Interventions for Populations Affected by Conflict in Six Countries". Preliminary results were presented at the Bank in November 2004, and they are promising. It is estimated that the cost of care is about $8 per patient and the return on this investment is estimated at approximately $40. Further work is underway to refine these data. In addition, the Bank has prepared a toolkit to guide interventions in mental health and psychosocial interventions in conflict-affected countries (Baingana and Bannon 2004). A brief description of the toolkit is presented in Box 2.

Box 2: Integrating Mental Health and Psychosocial Interventions into World Bank Lending for Conflict-Affected Populations: A 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 appropriate 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 and sources for more detailed information; (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 key sectors.

Source: Baingana F and Bannon I, 2004

In addition to the conceptual framework presented here, interventions should also be guided by a number of key principles. An overriding principle, as suggested by Mollica, is the notion that "the more intrusive the approach, the more negative the outcome" (Gewertz 2005, p. 3). In addition, the following key principles should be borne in mind in addressing mental health and psychosocial needs in conflict-affected settings (elaborated in greater detail 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 who 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 provided before they can help others.

- Exercise caution in supporting research or data collection on mental trauma among war-affected populations. In-depth clinical interviews designed to awaken 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.

- 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.

- Above all, do no harm. No intervention is preferable to a badly designed intervention.

APPROACHES TO MENTAL HEALTH AND PSYCHOSOCIAL PROGRAMMING: FIVE CONFLICT EXAMPLES

The following section describes mental health and psychosocial interventions in five conflict-affected settings: the West Bank and Gaza, Bosnia-Herzegovina, Burundi, Uganda and Afghanistan. Although each of these regions has experienced conflict, their unique situations require distinct approaches to meeting mental and psychosocial needs. The examples reflect interventions from a number of sectors, across care levels, and with the cooperation of multiple stakeholders. These country experiences illustrate possible entry points, approaches, and

processes for developing and implementing future interventions given diverse resources and needs.

WEST BANK AND GAZA: DIMENSIONS OF MENTAL HEALTH AND PSYCHOSOCIAL PROGRAMS

Burden of Mental Disorders in the West Bank and Gaza

It is difficult to measure precisely treatment and support needs in the wake of widespread and continuing violence. Studies on the impact of conflict on the Palestinians have focused mainly on the wellbeing of children, and they show that its impact has been substantial. Research on 796 Palestinian children showed that 80 percent began interactions by fighting with each other, 25 percent acted destructively, one third experienced headaches, one third suffered from sleep disturbances and 43 percent experienced depression (Baker 1990). Another study revealed that, for children, higher incidence of traumatic experience was related to increased difficulty with concentration, attention and memory (Qouta 2000). A third study showed that 80 percent of Palestinian children feared that Israelis would attack their homes, 35 percent showed fear symptoms, 22 percent exhibited withdrawal behavior, and 92 percent had nightmares (Punamaki 1996).

Following the most recent *Intifada*,[8] the Ministry of Health (MOH) Community Mental Health Program reported a 105 percent increase in the detection of new mental disorder cases, the majority of whom were children under the age of 18 years (World Bank 2001). WHO findings support this estimate by showing an increase in behavioral disorders among youth, who account for 69 percent of Palestinian casualties in the conflict. According to the Union of Palestinian Medical Relief Committees (UPMRC), 25 percent of Palestinians would benefit from psychological treatment to address stress caused by the conflict, political tension and economic distress (Qouta and El-Sarraj 2002).

Health Care Delivery in the West Bank and Gaza

In 1995 the total Palestinian population was estimated at approximately 3.5 million. Just three years earlier the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) reported that it had aided around 2.6 million of the Palestinian population who were registered as refugees in areas ranging from Lebanon and the Syrian Arab Republic, to Jordan, and the West Bank and Gaza (WHO 2004b). With its population scattered and lacking a strong, unifying governance structure, it is not surprising that a Palestinian health policy and strategy did not exist until recently. In 1990 the Palestinian Red Crescent Society and Palestinian health officials developed a national health plan for the Palestinian population. Among other things, the plan specifically called for the development of a mental health program (WHO 2004b).

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[8] Information on the West Bank and Gaza case refers to the situation as of 2001.

Health care in the West Bank and Gaza is provided by the Palestinian National Authority (PNA), NGOs, UNRWA, the Palestinian Red Crescent Society and by private practitioners. In the MOH, there is a Directorate for Hospital Services, responsible for care in all hospitals including the Bethlehem Psychiatric Hospital, a 320-bed facility, and the 41-bed Gaza Mental Health Unit. The Directorate of Primary Health Care has a system of Community Mental Health Clinics. The Community Mental Health Directors, one for Gaza and another for the West Bank, are in this Directorate. There are also separate positions for Directors of Rehabilitation Services, with one serving in the West Bank and one in Gaza. Rehabilitation of the mentally ill is included under their mandate but the Directorate is severely short of financial, human, and material resources. A separate Directorate is responsible for NGO coordination. The Ministry of Social Welfare has a position for Rehabilitation Services and the Ministry of Education is responsible for early child education as well as school health programs.

Mental Health Services in the West Bank and Gaza

As indicated by its place in the Palestinian National Health Plan development goals, mental health is a rising concern for Palestinians. The MOH bases its system on the Primary Health Care (PHC) model and thus has three levels of care; tertiary, secondary and primary. At the primary level, training is provided for primary health workers on how to recognize and manage common mental health problems. This training is organized by the MOH with French Government support. Community Mental Health Clinics have been established, with four serving the West Bank and four serving Gaza. At the tertiary level there are two psychiatric hospitals that are severely under resourced, and there are no mental health services (clinics, personnel or in-patient facilities) in district hospitals.

Table 3: West Bank and Gaza: Mental Health Services

		Government	NGO	UNRWA	Private Providers
Tertiary	West Bank	Bethlehem Psychiatric Hospital (320 beds) no beds for children			
	Gaza	Gaza Psychiatric Hospital (41 beds) 4 beds for children			
Secondary	West Bank				
	Gaza				
Primary	West Bank	4 CMH Clinics	3 NGOs as given by MOH, many others provide counseling	Short term programs according to funding	10 private clinics/consultation rooms run by Government-employed psychiatrists after official hours.
	Gaza	4 CMH Clinics 1 special clinic for children	GCMHP mainly but many others provide counseling	Short term programs according to funding	3-4 private clinics/consultation rooms run by Government-employed psychiatrists after official hours

A summary of some of the mental health services available for adults is provided in Table 3. There are no tertiary level services in the NGO, UNRWA and private sectors. However, the two MOH hospitals, one in Gaza and one in Bethlehem, appear to be adequate for the time being with an average bed occupancy rate of 50-65 percent. This low occupancy rate could be due to the prevailing stigma associated with mental disorders, the under-resourced hospitals leading to poor quality of care, and problems of access due to current and frequent closures. There are no mental health services (clinics, personnel or beds) in any of the general hospitals, whether in the Government, NGO, UNRWA or private sector.

At the primary level, services and units available are clear for the government sector but less clear for the NGO, UNRWA and private sectors. This is because many NGOs provide counseling as part of their other programs. Examples are the Spafford Clinic and the Palestinian Counseling Centre in East Jerusalem, the Jabalia Rehabilitation Society and the Palestine Avenir for Childhood Foundation in Gaza. None of these facilities are included within the government list of NGOs, but they all provide mental health services. However, the counseling provided is not regulated in any way and there does not seem to be any standardization of counselor training or service provision. Each NGO develops and implements its own counseling training program. Some of the NGOs working with women and children have begun to meet in order to begin to develop standards and guidelines and a regulatory framework for NGO mental health activities.

Services for children are largely provided by NGOs, often under Early Child Education Programs. There is also a Children's Mental Health Clinic in the El-Rimal PHC Clinic in Gaza, which is run by a psychiatrist and opens on Saturdays and Mondays.

From the above, it would seem as if the majority of public funds are spent on tertiary hospital care with virtually nothing at the secondary level and minimal funding at the primary level. This suggests an inverted funding pyramid, at odds with where the greatest needs are. The aim would thus be to try to change the allocation of resources to better match the disorders burden as illustrated in Figure 5.

BOSNIA-HERZEGOVINA PROGRAM: PRIMARY HEALTH CARE

Bosnia-Herzegovina's conflict was ethnic in nature and involved widespread violence against women and indiscriminate killing of the population. Bosnia-Herzegovina, a lower-middle income country, has a population of 4 million with a GNI per capita of $1,210. It spends 7.6 percent of GDP on health. It has 1.8 psychiatrists, 0.08 neurosurgeons, 0.4 neurologists, 10 psychiatric nurses, 0.5 psychologists and 0.03 social workers per 100,000 population. There are 3.6 psychiatric beds per 10,000 population (WHO 2001c).

As part of its efforts to recover from the conflict, Bosnia-Herzegovina, with the support of the World Bank, invested in the construction of Community Mental Health Clinics. At evaluation, it

was found that the clinics were being underused. In an attempt to improve mental health support, a project was developed by the Harvard Refugee Trauma Centre and supported by the Bank's Post Conflict Fund for 2000-01.

An important constraint on access to care, as reported by Primary Care Physicians (PCPs), was that they did not have adequate knowledge and skills to manage mental health disorders. In response, the project assessed the mental health knowledge and skills of PCPs in one district. Using the results, a PCP training program was developed and implemented, and a post-training evaluation was conducted. The results indicated that PCP knowledge and skills in managing common mental disorders improved markedly after the training and more patients were attending the Community Mental Health Clinics. The findings of an independent evaluation of the project indicated that its strengths and impacts included:

- Making the overall health care system more rational and logical in terms of the links between primary, secondary and tertiary care, and referral from one to the other;
- Familiarizing PHC non-psychiatric staff with the concept of mental health and the need for its protection;
- Demonstrating the importance of a bottom-up approach to the logical development of projects, and the value of situation and needs assessments;
- Encouraging health staff to participate as stakeholders in the change process; and
- Encouraging stakeholders to see the project as a national one, with its own character, which could improve prospects for sustainability (Carballo 2003).

BURUNDI PROGRAM: EARLY CHILD DEVELOPMENT

Following the 1994 Burundi genocide, a large portion of the population was internally displaced and some became refugees in Tanzania. Stability is not fully restored, HIV/AIDS levels are high, poverty is widespread and the country has been affected by drought. Burundi has a population of 7 million with a GNI per capita of $120, and spends 4 percent of GDP on health. The country has 0.02 psychiatrists, 0.02 neurosurgeons, 0.06 neurologists, no psychiatric nurses, 0.2 psychologists and 1.5 social workers per 100,000 population. There are 0.1 psychiatric beds per 10,000 population (WHO 2001c).

The World Bank supported a Burundi Second Social Action Project (BURSAP 2) that included an Early Child Development component covering nutrition, health and psychosocial needs. A Burundian NGO, Twitezimbere, was in charge of implementing the Early Child Development component and, through a process of community mobilization, assisting the target villages (*sous-colline*) in creating mothers' committees in each community. The committees selected 12 members who formed "executive bodies", then made house-to-house surveys and recorded all village children age six years and under. Each village had 80-150 children in the target age group.

The Committees selected four people to be trained as teachers. Discussions on establishing a community Early Child Care Center were held with each mother with children ages six and under. During the meetings, the mothers' willingness to participate in the program and contribute to the remuneration of teachers was evaluated. The communities were asked to provide space for the Center and, in places where no appropriate building was available, provide labor and materials for its construction. The Bank project provided the roofing materials.

As this was going on, a Burundian psychologist was commissioned to develop a training package, including a training-of-trainers manual, teachers' handbook and educational aids. The psychologist formed a team with another psychologist and an early child education teacher to assess the knowledge and literacy levels of the selected mothers. Based on their findings, they developed the training-of-trainers manual, which was then discussed with the Ministry of Education, key NGOs and early child education specialists. The tools were used to train mothers in child nutrition, health and psychosocial needs, and support the Early Child Care Center teachers.

Box 3: Early Child Development in Burundi

When the International Rescue Committee (IRC) conducted a survey to evaluate the needs of children in Burundi, they were taken aback by 10-year-old Zebedi's evaluation of his circumstances. As Zebedi explained, "Of course, we would like to play football and other games, but what we really want and need is to learn how to read and write" (IRC 2001) According to IRC, Zebedi's desire was echoed by children across Burundi. Despite his determination, Zebedi may already be at a learning disadvantage.

Experience in the early stages of child development directly impacts future physical and mental health, learning and behavior. Studies show that the first three years are especially crucial for the growth and development of the brain and that lack of stimulation may lead to a 20 to 30 percent reduction in brain size (Torkington 2001). According to the local NGO Twitezimbere, a significant number of Burundian children show comparatively weak physical, psychological, social and emotional development. Despite the obvious need, formal pre-schools cover, at best, only 1 percent of all children. The gross primary school enrollment rate, furthermore, has remained below its pre-crisis level, at 63 percent. In order to ensure the healthy development of Zebedi, his peers, and their younger siblings, expanding educational opportunities for Burundian children is critical.

To date, the interventions have reached 34 communes and 78,912 households, 1,330 mothers have been trained, 196 pre-school circles formed, 16,451 pre-school students taught, and a total of 600,000 children reached by the program. Although the longer-term impact of the program has not been evaluated, preliminary results indicate that children attending the pre-school activities are doing better during their first year of primary school than their non-attending peers.

PSYCHOSOCIAL PROGRAMS IN UGANDA

Ongoing conflict has plagued the northern part of Uganda for the past 15 years. The rebels have abducted children from schools, chopped off the mouths of villagers who gave evidence to the Government, raped women, and killed villagers indiscriminately. The Government decided to put the populations of the most affected areas into camps, so that the army could provide protection but also to prevent the population from giving support to the rebels. A part of the population was also internally displaced in neighboring districts where the District Administration established IDP camps with support from UNHCR and the Red Cross, while others went to Sudan and the Democratic Republic of the Congo. Eight of the 45 districts of Uganda were affected by this conflict. NGOs were providing interventions for the affected populations, but it was not clear who was doing what, who had access to what services, and what the geographic coverage of services was, or how the interventions impacted target groups.

Uganda has a population of 24 million with a GNI per capita of $320, and spends 4.1 percent of GDP on health. It has 0.04 psychiatrists, 0.009 neurosurgeons, 0.02 neurologists, 2 psychiatric nurses, 0.05 psychologists and 0.09 social workers per 100,000 population. There are 0.44 psychiatric beds per 10,000 population (WHO 2001c). The northern areas affected by conflict have fewer resources than the rest of the country.

An assessment was carried out by a team led by two Government sectors, a MOH staff (National Mental Health Coordinator) and a staff member of the Ministry of Gender, Labour and Social Development (Child Protection Officer), and included five NGOs working on psychosocial issues. UNICEF supported the work. The Team initially held a workshop with representatives from each of the affected districts. During the workshop, an attempt was made to carry out a situation analysis and to determine the extent of the problem, available interventions and gaps. Through the workshop, it became evident that a more systematic assessment was needed.

Assisted by a facilitator, the Team developed an assessment strategy, outlining the interview guides, and carried out the assessment using a variety of participatory methods. The initial findings were disseminated at a consensus workshop involving key policy makers and NGOs from the affected districts. Their recommendations were integrated into the final report.

The results were disseminated to each of the districts in separate workshops, since the districts were the decentralized planning and implementation governance level for all activities. Each of these workshops included key administrative officials, NGO and UN agency representatives. The workshops were designed to assist the participants in planning psychosocial interventions relevant to their districts, and taking into account the assessment findings.

Some of the recommendations made and the outcomes included:

- **Strengthen district planning:** Each district developed a multi‑sector psychosocial plan that was integrated into the District Development Plan.

- **Strengthen coordination at three levels:** The Core Team was formalized as the national coordinating body for psychosocial issues. A system for regional coordination, involving three to four districts each, was established and was scheduled to meet once every quarter. District Psychosocial Committees were formed and met once a month.

- **Standardize counseling training and provision:** The Core Team developed guidelines for counseling provision and a regulatory framework.

- **Share resources:** Examples include NGOs providing space in their vehicles to transport government officials and other NGO staff for supervision or service provision. One NGO had a counseling training program and offered to train other NGOs that needed to strengthen their counseling programs.

- **Strengthen and coordinate advocacy efforts:** One NGO, the Concerned Parents Association, was able to work with another NGO (GUSCO) that provided interventions for abducted children. Drawings by abducted children were compiled into a book by a third NGO (AVSI) and used as advocacy materials by the Concerned Parents Association at events in Uganda, Rome and Geneva. As a result, pressure was exerted on the rebels and some of the abducted children still in captivity were released. The Core Team, working with the District Committees, facilitated the safe return of children to their districts, tracing and resettlement with families, and provision of psychosocial rehabilitation.

- **Distribute funding:** MOH provided a small grant to the NGO Hope After Rape (HAR) so that it could provide nine months of training in counseling to district nurses in one of the districts.

- **Outline research guidelines:** Guidelines were developed for how research should be carried out, the manner in which results should be disseminated to study populations, and on strengthening the capacities of districts to regulate research on their populations.

AFGHANISTAN: BUILDING FROM THE BOTTOM UP

Afghanistan has a population of about 26 million, GNI per capita of about $250 (2002), and spends 3.2 percent of GDP on health. It has 0.036 psychiatrists, 0.034 neurosurgeons, 0.07 neurologists, 0.07 psychiatric nurses, no social workers, and 0.09 psychologists per 100,000 population. There are 0.027 psychiatric beds per 10,000 population (WHO 2001c), one 60‑bed mental hospital in Kabul, a 50‑bed psychiatric ward in another Kabul hospital, and one outpatient center in Jawzjan Province (IRIN 2003).

Afghanistan has been devastated by two decades of conflict and prolonged drought. A shattered economy, a breakdown of basic services, continued insecurity, and large numbers of refugees and IDPs have had devastating social effects on Afghanistan's population. These

factors, in turn, have led to psychosocial and mental health problems, including depression, domestic violence, anger, criminal activities, alcohol and drug abuse, and an increase in suicide rates.

As a consequence of the conflict, there are an estimated 1-2 million IDPs in Afghanistan, and high numbers of refugees scattered around the region, in countries including Pakistan (2 million), Iran (1.4 million) and Uzbekistan, Tajikistan and Turkmenistan (400,000). Estimates further indicate that there are 800,000 disabled people in Afghanistan, 200,000 of whom are disabled as a result of land mines.

Psychiatrist Sayed Afundi estimates that 70 percent of Afghan mental disorders are war-induced (Liu 2001). According to Khitab Kaker, director of the Kabul Mental Hospital, 20-30 percent of Afghans suffer from mental disorders, while 40-50 percent suffer from anxiety (Sharifzada 2004). Kaker's estimates are considerably lower than figures published in the Journal of the American Medical Association in 2002, which indicated that 68 percent of Afghans were depressed and 72 percent showed symptoms of anxiety. Box 4 illustrates the range of mental health problems and resource constraints currently faced in Afghanistan.

Box 4: Mental Health in Afghanistan: Addressing a Large Problem with Limited Resources

Decades of war have ravaged Afghanistan and time and again its people have picked through the rubble to rebuild their lives. The toll on the Afghan population has been severe, especially with regard to mental health. One former Army general admits to being overcome by rage so acute that he sometimes fails to recognize his family members. A father who lost his son during the conflict is cared for in Kabul's Mental Health Hospital, his hands and feet tied together to protect himself and those around him from his trauma-induced hallucinations. One doctor reports that it is not uncommon for amputees, with little hope for future employment, to try to jump from his hospital's balcony. Far too many have been successful (Liu 2001).

Afghanistan is severely under-equipped to address mental health and psychosocial problems. Supplies, staff and training are limited. Psychologist Taimur Shah, of Kabul's Mental Health Hospital, explains that when he heard the sound of breaking glass in the night it took much too long to get to his injured patient since he had to first light an oil lamp to navigate in the dark. Yet, despite the limitations, Shah asserts that his patients are better off than those in some rural areas where the "best practice" for treating mental illness means that the ill are starved and chained to trees (Sharifzada 2004). Although psychologist Abdul Menon Hakiar is hopeful for the future, he acknowledges that while it will take time and resources to address mental and psychosocial problems, there is also a need to reduce the widespread stigma surrounding mental health disorders, which limits funding and hinders treatment.

A World Bank team visited Afghanistan in early 2003 to assess the feasibility of providing support to the mental health services. Although mental health was included as one of the seven

components of the Basic Package of Health Services (BPHS), after evaluating the costs of the package, MOH felt that it would not be possible to implement the mental health and disability activities immediately. Although MOH included mental health in its organizational chart under the Primary Health Care Directorate, as of early 2003 the offices were not active.

During the Bank's assessment, meetings were held between some of the key mental health stakeholders in Afghanistan, including the MOH Director of Mental Health Services (also Director of the Mental Health Hospital in Kabul), the Deputy Director of the Mental Hospital, WHO, UNICEF, Management Sciences for Health (MSH), HealthNet International (HNI), Save the Children USA and IRC. A visit to Wardak Province also provided some insight into available services at the provincial hospital and health center, challenges to the provision of mental health services, mental disorder burdens at the hospital and health center levels, and perceptions and knowledge of mental disorders within the community.

Taking Stock

As a result of the stakeholder meetings it was determined that:

- **Policy:** To begin addressing Afghanistan's mental heath needs, the Mental Health Act of 1987 needed revision and a mental health policy, standards and guidelines needed to be established. WHO would support development of a mental health policy.

- **Coordinating Stakeholders:** There was no link between MOH headquarters and the provincial hospitals, and coordination with NGOs and UN agencies was just beginning.

- **Training:** In Afghanistan, undergraduate training in psychiatry is only two weeks and is insufficient to equip doctors to manage common mental health problems. WHO had provided a manual for training nurses to recognize and manage common mental disorders, and in Kabul and neighboring areas, 20 nurses, 20 psychologists and 60 doctors underwent training.

- **Community Mental Health Services:** The Director of Mental Health had attempted to pilot community mental health services in six polyclinics of Kabul but was not able to get space allocated for mental health. He had intended to have a psychiatrist, psychologist and a social worker in the clinics two mornings a week.

- **Provincial Mental Health Services:** There are no mental health services in the provinces. Although doctors in 10 provinces have been trained, they do not have drugs and no support supervision is provided after training, as MOH does not have the vehicles or resources.

- **Hospital-based Services:** The Mental Hospital in Kabul is the only mental hospital in the country. It has 60 beds and bed occupancy is often over 100 percent. Fifty to seventy percent of patients are seen daily in the outpatient department, which is a small room in the hospital where children and adults are treated. There are no other facilities for children, except for the Children's Neurological Clinic. The hospital has 25 "psychiatrists," who received a three-month diploma in psychiatry, funded by WHO.

The 50-bed neuropsychiatric unit in one of Kabul's hospitals also serves patients with mental disorders. Problems range from stroke and psychotic disorders to drug abuse; a big problem in Afghanistan, especially among returnees from Iran and Pakistan. The United Nations International Drug Control Program is supporting a survey to determine the extent of drug abuse problems in the Kabul area.

- **Mental Health Resources:** MOH provides salary for staff and food for patients but has no money for drugs. Patients have to buy drugs in the bazaars and the quality is often not ensured. The hospital has no laboratory, no X-ray unit, no ambulance and no toxicology laboratory. Self-medication is common among patients with mental disorders.

Recommendations for Strengthening the Mental Health Program in Afghanistan

The following are recommendations that were made following the mission.

Short Term: One Year

- **Separate the positions of MOH Mental Health Director and Director of the Mental Hospital:** The role of the Mental Health Director would be to lead formulation of a mental health policy, development of standards and guidelines, coordination of donor and NGO activities, resource mobilization, planning, budgeting, and support supervision. He would also have the key role of linking into ongoing MOH activities. The role of the Director of the Mental Health Hospital would be to coordinate the day-to-day running of the hospital, participate in the teaching of medical students, nurses, and other health personnel, and participate in the provision of support supervision to the Regional Hospitals, with MOH support.

- **Establish a Mental Health Coordinating Committee:** Members of the Committee could include the Head of the Nurse Training Institution, WHO, UNICEF, and key NGOs providing mental health or psychosocial services such as HealthNet International (HNI) and Save the Children USA. The role of the Committee would be to provide support to the Mental Health Director in planning mental health programs, resource mobilization, coordination of activities and information sharing.

- **Include the Mental Health Director in the Psychosocial Working Group:** This would allow him to coordinate with and complement the activities of the Working Group.

- **Collect information on the prevalence of mental disorders and services provided:** This would be a job for the Mental Health Director, and would include data from the *Disability Survey* supported by the Centers for Disease Control (CDC), the ongoing epidemiological survey of Nangarhar, also supported by CDC, UNICEF/Save the Children USA *Children of Kabul Report*, and regular reports from HNI.

- **Encourage provincial directors to identify a designated Provincial Mental Health Coordinator:** The Coordinator would develop a provincial mental health strategy, collect data, mobilize resources, and coordinate training for health personnel in

the province. If funds were available, he/she could also provide support supervision to the health units in the districts.

- **Organize a workshop for all the Provincial Mental Health Coordinators at least once a year:** This would allow the Mental Health Director to gather information on activities in the provinces, carry out training on planning and budgeting, and allow the Provincial Coordinators to learn from each other.

- **Develop a work-plan for the fiscal year:** In developing the work-plan, first step activities could include awareness raising of the Regional and Provincial Directors in mental health, and planning for support supervision to the regional hospitals. Care should be taken not to set up a vertical mental health program.

- **Support the HNI mental health program:** If funds are available, the HNI mental health program (Box 5) should be supported. This would provide resources, such as training manuals, as well as the process for integrating mental health into primary health care. It would also aid in determining the cost-effectiveness of interventions, since the baseline survey is currently underway with a follow-up planned once the program has been running for some years.

Box 5: HealthNet International's (HNI) Approach to Mental Health in Afghanistan

HealthNet International (HNI) is a Dutch NGO formed in 1992 as an offshoot of Médecins Sans Frontières (MSF) Holland, with the aim of supporting the revitalization of health care systems in post-conflict reconstruction.

HNI began activities in Afghanistan in 1992 with the national Malaria and Leishmaniasis Control Program, and the Health Care Support Program. The latter operates in 9 districts of Nangarhar Province. HNI provides support to MOH, has built 2 rural hospitals, and provides support to 12 Basic Health Centers. In each of the districts where it operates, Village Health Committees (VHC) have been formed and Village Health Volunteers (VHV) selected by the communities. The 250 VHC meet once a month.

The Mental Health Program began with an assessment in January, 2002, which provided an overview of priorities in mental health care and psychosocial support in Nangarhar, an outline for a community mental health program, an implementation plan for mental health care and another for psychosocial care. The five phases of the program are:

- **Preparation**, which includes the assessment.

- **Demonstration**, which involves implementation in three districts. This is currently underway and began with an assessment of local idioms of distress and community opinions regarding the prevalence of mental disorders, development of training modules, and training. Nurses and midwives were trained for one week and VHVs for two days. The training of traditional birth attendants was planned.

- **Scaling up** to the other districts where HNI is running its health program.

- **Maintenance** of the program in the HNI-supported districts. This will involve refresher

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courses for all the personnel trained, and support supervision once training is carried
out.

- An **expansion** phase to extend the program to other provinces, not limited to HNI-supported areas.

A pre-test and post-test is administered for each training course and an evaluation is carried out after each session. A baseline was developed in the three districts where the training began. Four hundred patients in the outpatient department were assessed using the Hopkins Symptom Checklist-25 (HSCL 25) and the Harvard Trauma Questionnaire (HTQ) before they saw doctors, then the diagnosis and treatment were compared with the results of the tests. The aim was to see how many of the doctors recognized mental disorders and how many were able to provide the correct treatment. This will be repeated after the demonstration phase to determine if there is an improvement in the recognition and management of mental disorders. HNI also provides 10 essential mental health drugs. The patients pay 60 percent of the cost of the drugs as a form of cost recovery.

Medium Term: Two to Three Years

- **Develop a mental health policy.** In the second year the Mental Health Director would have a better sense of the mental health burden, available resources, and a fuller understanding of how a community mental health program can be organized. It would thus be a good time to get the various stakeholders together to develop the mental health policy and to begin implementation.

- **Strengthen data collection and utilization.** The process of strengthening the routine collection of mental health data from the provinces and its utilization at the provincial and national levels should continue during this period.

- **Strengthen mental health training in the medical and nursing schools.** The undergraduate curriculum includes only two weeks for mental health with no clinical orientation. The curriculum could be revised to lengthen the period spent on mental health to at least 10 weeks, including clinical sessions. The nurse and midwifery training curricula should also include mental health components with clinical orientation, lasting at least 4 weeks per year in a mental health ward/hospital.

Long Term: Four to Six Years

- Conduct a comprehensive, nationwide epidemiological survey.

- Carry out impact assessments of the programs after 3-4 years of implementation.

- Review the Mental Health Policy and Strategic Plan.

In Afghanistan, mental health services are fragmented, with a focus on hospital-based care. Only one NGO, HNI, is providing community mental health services. Although there is a close relationship between mental health and psychosocial interventions, at present, the provision of psychosocial services is not complemented by mental health services in communities and this gap could negatively impact on the effectiveness of psychosocial programs. Provision of care in

the primary health level ensures that interventions are accessible to the population as well as ensuring early interventions to limit or prevent disability.

In 2003, MOH felt it would be better to postpone mental health activities until the Director of Mental Health had been appointed and after he/she had a better sense of the current situation. Mental health is considered part of the "second tier" of the BPHS. In 2004, MOH created the position of Director for Mental Health. The position is separate from that of the Director of the Psychiatric Hospital. A Mental Health Coordinating Committee was formed that includes key stakeholders, such as other Government Sectors, NGOs, and UN agencies, including WHO and UNICEF. The Director of Mental Health, with the collaboration of the Mental Health Coordinating Committee developed a Mental Health Strategy document with an implementation plan.

At the time of writing, it is clear that the Government of Afghanistan adopted the recommendations outlined above. The challenge now is mobilizing the resources to finance the strategy. The work and discussions carried out in Afghanistan, coupled with the proposed strategy that emerged may be a useful reference for other countries emerging from conflict and where donors and the government may be interested in supporting longer-term approaches to address mental health and psychosocial disorders.

REMAINING CHALLENGES

ADAPTING TO CULTURAL AND HISTORICAL CONTEXTS

In planning mental health and psychosocial interventions it is critical to consider the cultural and historical context in which they will be implemented. Just as approaches that are effective in developed countries may not be applicable in developing countries, approaches that are successful in one developing region may not serve the needs of another. As De Jong explains, "Models implemented in a specific country are often determined by social or colonial history and often need thorough transformation to be effective in post-war circumstances" (2002, p. 24). These transformations may be difficult to bring about when previous systems are entrenched in public perceptions of health care. For example, former Soviet Block countries, which came to rely on centralized medical authority and the care of specialists, may have difficulty accepting mental health treatment at the primary care level (De Jong 2002).

THE LACK OF CONSENSUS IN DEFINING "PSYCHOSOCIAL"

There is little debate that conflict-affected populations have serious mental health needs that must be met. However, as the relationship between mental health and social and cultural factors becomes more widely acknowledged, the need for broader, psychosocial interventions is gaining recognition. One major challenge to providing psychosocial support in conflict and post-

conflict situations is in establishing a consensual definition of what is meant by psychosocial. Although it is generally understood that "psychosocial interventions seek to positively influence human development by addressing the negative impact of social factors on people's thoughts and behaviour," the absence of a concrete definition and lack of essential components for psychosocial programming are obstacles to intervention (Loughry and Eyber 2003). These deficits lead to a limited understanding of psychosocial, confining it to psychiatric disorders that require intensive counselling and therapy, thereby missing the extent of its real potential. The Psychosocial Working Group, composed of a number of academic partners and humanitarian agencies including Mercy Corps, IRC, MSF, Save the Children, and the Christian Children's Fund, is currently working to address these issues within the context of complex emergencies.

INTERVENTION EFFECTIVENESS: A LACK OF SCIENTIFIC EVALUATION

The lack of systematic, scientific studies that support the need for mental health and psychosocial interventions in conflict and post-conflict settings remains an obstacle to more effective and better targeted interventions. As previously discussed, the deficit in information is not surprising when the many needs of conflict-affected populations are viewed relative to the limited resources available. Yet, limited funding and resources are exactly the reason why determining effectiveness is critical. This, coupled with the possibility that misdirected interventions can do more harm than good, are reasons why compiling and analyzing data must be a priority. Areas for further research include:

- Whether and how mental health and psychosocial 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. A strong link 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.

NEED FOR CONCERTED INTERNATIONAL ACTION AND COORDINATION

There is a definite need for coordination among governments, UN agencies, NGOs and donors to address mental health and psychosocial issues within the framework of post-conflict reconstruction. With the support of the World Bank and a number of other agencies, the Harvard Program in Refugee Trauma (HPRT) is working to meet this need by developing a Global Action Plan to identify and disseminate best practices for the mental health recovery of post-conflict societies. In 2002, HPRT organized a meeting with ministry of health officials from

six conflict-affected countries in Asia, Africa, Europe and Latin America. The goal of the meeting was to identify barriers to developing and sustaining viable mental health services.

Working closely with its development partners, HPRT will select 10 post-conflict countries willing to document their mental and psychosocial experiences and practices. A team from HPRT will be sent to each of the countries so that their experiences can be validated and the reporting standardized. Evidence-based best practices will be compiled to be used as a guide for future mental health and psychosocial interventions in conflict and post-conflict societies.

On December 2-3, 2004, a group of 35 ministers of health from countries struggling to recover from the effects of widespread violence, met in Rome to endorse a science-based, culturally effective, and sustainable mental health action plan for post-conflict recovery. The meeting was organized by Project 1 Billion, named for the more than one billion people worldwide who have suffered the effects of mass violence. The Project is sponsored by HPRT, Caritas Roma, Instituto Superiore di Sanita (Italian National Institute of Health), the Fulbright New Century Scholars Program, and the World Bank (including funding through the Post-Conflict Fund), with the support of the Italian Ministries of Health and Foreign Affairs, and WHO. The *Project 1 Billion Book of Best Practices: Trauma and the Role of Mental Health in Post-Conflict Recovery* was presented at the Rome gathering. The book, produced by leading international authorities in health, economic development, human rights, and anthropology aims to serve as a guide for governments, policy makers and donors in conflict-affected societies.

RECOMMENDATIONS: WHAT ROLE FOR THE WORLD BANK?

This paper has argued that mental health and psychosocial interventions are necessary and feasible in conflict-affected countries. The Bank generally plays a leading role in assisting countries to recover from the effects of conflict and return to a path of sustainable development once the violence has ceased. A focus on mental health and psychosocial wellbeing is fully in line with the Bank's overriding mission of poverty alleviation, and with OED's recommendations on the role of the Bank in conflict-affected countries. The cases briefly reviewed in this paper suggest that Bank teams can draw on a growing body of experiences and approaches that can be adapted to different conflict settings and post-conflict reconstruction programs. Much of this experience lies outside the Bank, among UN agencies and specialized NGOs, which suggests that in most instances the Bank's comparative advantage and effectiveness in addressing mental health needs in conflict-affected settings will hinge critically on its ability to play a catalytic role and develop productive partnerships with more specialized and on-the-ground agencies and NGOs.

ANALYTIC AND ECONOMIC AND SECTOR WORK

The Bank can use its full array of analytical and technical assistance instruments to gain a better understanding of the role of mental health and psychosocial wellbeing in conflict-affected countries, as well as to address key remaining challenges. Below are some tentative suggestions on areas and issues that would benefit from additional analytical support and where there is a need to draw lessons and good practices:

- Whether mental health is an important factor in determining participation, which in turn can improve prospects for sustainable development in post-conflict countries;

- Whether and how mental health and psychosocial interventions influence the formation of positive social capital, and its links to 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 wellbeing of women in order to influence the health, nutritional and educational outcomes of their children.

- What are the cost-effective mental health and psychosocial interventions that can be developed for populations affected by conflict? Evaluations of the successes and challenges of these interventions and programs are critical to determining how future programs can be developed and adapted to different conflict settings.

- Lessons and good practice in early diagnosis of mental and psychosocial disorders in communities affected by conflict. Building on the experience of Burundi, there is a need to document further and evaluate the use and adaptation of living standards surveys to assess the extent of mental health problems.

- The scope for incorporating survey and diagnostic findings in Bank poverty diagnoses and assessments should be evaluated and good practices disseminated.

OPERATIONS

Documentation and dissemination of Bank projects that have included mental health and psychosocial components, such as the Bosnia HPRT Project, the TPO Six Country Cost-Effectiveness Study, the Burundi Second Social Action Project, the Burundi Mental Health and Alcohol Use Module in the Core Welfare Indicators Questionnaire Survey, and the Bosnia-Herzegovina Living Standards Measurement Survey.

- Integration of mental health and psychosocial components into projects for conflict-affected populations. These could be in education, health, social action, legal and

judicial reform, nutrition, ECD, Multi-country HIV/AIDS Programs (MAPs) in conflict-affected countries, demobilization efforts, etc. The process adopted, the Bank instruments used, and the outcomes would be valuable to other task managers in the process of developing similar projects.

- Guidance on partnering with specialized agencies and NGOs, as well as key stakeholders, in the design and implementation of mental health projects would be helpful to country teams considering interventions and approaches to project design.

CONCLUSION

The paper has argued that the World Bank has an important role to play in addressing mental health and psychosocial needs in populations and communities recovering from the effects of violent conflict. The mental and psychosocial wounds induced by violence and traumatic experiences do not disappear with the return to normalcy, and if not addressed may well become an important constraint to efforts that aim to support reconciliation and the reweaving of a post-conflict society's social fabric. Building on a small but growing body of Bank experience and that of other stakeholders outside the Bank, the paper has presented a conceptual framework to guide future Bank efforts in this area.

The case studies briefly presented here illustrate that it is possible to develop mental health and psychosocial programs in different sectors and with very different approaches. The case studies also demonstrate that in all interventions, there is a need to ensure coordination and collaboration within the health sector, (e.g., between primary health care and mental health), but also with other sectors outside of health. Coordination among the government, NGOs and the private sector is also vital to the success of mental health and psychosocial programming.

The major challenge to mental health and psychosocial programming is the lack of documentation of evaluated programs. These would provide process and outcome/impact indicators that would be useful for scaling up or replicating effective programs and interventions.

In the case of the World Bank, it will be necessary to invest in collating information on the mental health and psychosocial programs that have been supported, their longer-term impacts, challenges and good practices that can benefit other country teams confronted by similar problems. This information, if disseminated widely within the Bank, would go a long way toward influencing the further formulation of mental health and psychosocial components within health, education and social protection projects.

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