

Project 1 Billion

International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery

MENTAL HEALTH ACTION PLAN ©



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PROJECT 1 BILLION OVERVIEW

The social and human costs of mass violence are staggering. More than 1 billion persons in over 47 countries today have been affected by mass violence, embodied in the experience of war, ethnic conflict, torture and terrorism. The last century has been described as the “refugee century” with international targeting of civilians and human suffering showing no signs of abating in the 21st century.

Recent scientific studies have revealed the enormous mental health impact of human aggression on the health status and daily functioning of traumatized populations. However, for most nations affected by mass violence, mental health policy is essentially non-existent; there is no standardized global approach to the mental and physical healing of traumatized populations. Fortunately, modern science has demonstrated the capacity of local primary health care systems, traditional healers, and national and international non-governmental organizations (NGOs) to play a major role in reducing the suffering and disability associated with mass violence. Mental health policies in post-conflict settings are now capable of helping to create the proper environment for socio-cultural and economic development, as well as reconciliation.

Project 1 Billion is an historic initiative that began when seven Ministries of Health from Afghanistan, Cambodia, Bosnia, Indonesia, Peru, Rwanda, and Uganda met with over 18 country representatives, and major UN Agencies (e.g. WHO, UNICEF) and donors in Sarajevo, Bosnia and Herzegovina in September 2002. At the Sarajevo meeting, Project 1 Billion was formulated and the Rome working group of all post-conflict Ministries of Health was planned as the critical next step. An Action Plan and science-based Book of Best Practices were proposed. The Rome conference in December 2004 was envisioned as a halfway point toward the implementation of a global mental health Action Plan that is science-based, culturally adaptable to different settings, and cost efficient.

At this meeting, the Ministries of Health and participant international policy planners and donors will be able to recommend strategies for the implementation, dissemination and funding of the Action Plan. Methods of monitoring and evaluating short and long mental health outcomes will also be included in the Project.

PROJECT 1 BILLION MISSION STATEMENT

The overall mission of Project 1 Billion is for the national Ministries of Health from the world's post-conflict nations to:

- I. Review a science-based Action Plan for implementing and financing scientific, culturally effective and sustainable mental health programs in post-conflict countries.
- II. Disseminate a Book of Best Practices prepared by leading international experts from developed and developing nations, capable of helping post-conflict nations achieve significant mental health outcomes.
- III. Generate a mental health research agenda for evaluating the effectiveness of the Action Plan and for providing empirical evidence for individual and social recovery.
- IV. Establish an international dialogue and network of global cooperation between Ministries of Health, UN Agencies, governments, non-governmental organizations and major international donors on mental health policies and programs.

PROJECT 1 BILLION MENTAL HEALTH ACTION PLAN

The following document provides Ministers of Health from post-conflict countries with scientific and culturally effective and sustainable mental health action plan for caring for survivors of mass violence and traumatized populations.

1. MENTAL HEALTH POLICY AND LEGISLATION

The Ministries of Health (MOH) in post-conflict countries are in an ideal situation to take over the responsibility for the design and implementation of a science-based national mental health recovery plan that is culturally effective at the local level. While the health and well being of all citizens should be a national state goal, the MOH, along with their allied Ministries, such as education, labor, economic development, justice and finance are properly situated to assess and assure access to mental health care, provide science-based interventions, and mental health related public health information to the general population.

The MOH should also be responsible for the coordination of all mental health activities by local and international non-governmental organizations (NGOs), UN agencies, and international donors. MOH can also develop and monitor a simple, scientifically valid and reliable national mental health data system capable of informing national public health policy. This requires that the MOH, as the lead agency in mental health recovery, has a national mental health action plan that can be fully supported and financed by the national government through mental health policy and legislation.

1.1

MOH must work closely with national legislative and political authorities to assure that a mental health policy agenda exists, aimed at national and local post-conflict recovery.

1.2

Establish a reasonable timetable (e.g. five years) and terms of reference at the onset of the mental health action plan for the legislative next step that will follow the completion of the initial action plan. A national mental health policy that includes an action plan is the first step toward establishing mental health legislation through the country's parliamentary and legislative structures.

1.3

Conduct a national survey, at the beginning of the mental health recovery phase, of national and local resources including institutions and practitioners capable of delivering a culturally effective and scientific mental health response.

1.4

Convene a series of meetings with key stakeholders and relevant experts to define the mental health needs of the general public and the training needs of national and local institutions and practitioners.

1.5

Establish a simple data base and data collection system for monitoring relevant mental health indices for adults, adolescents and children in order to establish the mental health status of the general population at any given time and the changes in this status related to the relative effectiveness of mental health policy.

1.6

Guarantee national commitment of funding to assure a basic level of mental health care and prevention.

1.7

Impose requirements that all government health care projects have a mandatory mental health component and that all international programs (e.g. HIV/AIDS; landmines) have a mandatory mental health component.

2. FINANCING OF MENTAL HEALTH RECOVERY

Without adequate funding and financial support, no health or mental health action plan can be successful. To date, no major international donor, UN agency, or national government has established a clear set of guidelines for obtaining the financial resources for establishing and sustaining culturally effective mental health activities over time. It is the usual case that immediately after the close of a conflict, there is a large influx of international support for health, and sometimes mental health activities. After this initial build-up of mental health resources, financial support is withdrawn leading to the collapse of the promising, but embryonic mental health initiative. In spite of the fact that initial donor support is short lived, mental health problems not only do not subside, but usually grow in size and effect as the recovery phase encounters expected political and economic problems. At the outset of any international mental health intervention, MOH should decide who is going to pay for mental health services and prevention, and what is the relative percentage of financial support by international donors and the national government in order to sustain a mental health action plan over time.

2.1

Establish the unit costs for mental health services within the country's *indigenous healing system* in all relevant settings, such as community-based treatment facilities and hospitals. The *indigenous healing system* includes primary health care, the traditional healing system (i.e. religious and folk healers), family members, school-based counseling programs, and local and international NGOs.

2.2

Define basic or minimum mental health services and determine costs. During the acute phase international donors need to be asked to support the mental health aspect of any health reform, allocate resources to mental health programs, and develop a financing system to maintain continuing mental health care.

2.3

Decide the mechanisms for long term financing including contributions from international donors, the national social fund, patient fees, linkage to private business (e.g. using private enterprise to support mental health services) and voluntary/charitable contributions.

2.4

Establish a sustainable mental health financial plan that coordinates the financial resources of all contributors, including NGOs, that is a reasonable cost, provides decent minimum standards, and is cost efficient (primarily uses local labor and institutions whenever possible).

2.5

Establish a symbolic minimum payment by users (i.e., patients and clients) that can be a very small fee, a donation of voluntary labor, or both. Mental health consumers are often the poorest segment of post-conflict societies and rarely can make a substantial financial payment to support their mental health care. It is, however, essential that mental health patients/ clients feel they are making at minimum a symbolic contribution to the mental health system. This must be done in a culturally appropriate way that does not place additional financial burden on the patient/client, but emphasizes the important value placed upon on their “support” of their mental health practitioners and institutions.

3. SCIENCE-BASED MENTAL HEALTH SERVICES

Recent scientific studies have resolved the high prevalence of serious mental health disorders, such as depression and posttraumatic stress disorder (PTSD) in post-conflict societies. Vulnerable groups such as sexually abused survivors, prisoners of war (POWs), and those families whose children and family members have disappeared or have been murdered are at particularly high risk for psychological and social problems. The mental health effects of conflict and other forms of extreme violence due to human aggression can be chronic and socially and economically disabling. Mental health problems, if untreated, can also develop into serious health problems, including hypertension, cardiovascular disease, diabetes and cancer. Therefore, valid and reliable measures of emotional distress, and psychosocial disabilities must be integrated into early screening identification and treatment.

The utilization by MOH of scientifically validated mental health services has a number of major dimensions that include:

- (1) Establishing mental health services in the indigenous healing system based upon available scientific information. This information is readily available to MOH through international agencies such as WHO, scientific publications and local/international universities and medical schools. Public health experts, scientists, researchers and scholars exist in all societies.
- (2) While a hierarchy of scientific evidence exists with randomized clinical trials and longitudinal studies as the leading gold standards, few of these types of studies have been conducted in post-conflict societies and complex humanitarian emergencies. Data does exist from related areas (e.g. primary care medicine in developing countries) and from qualitative and ethnographic research in conflict situations. Available research can help MOHs develop a scientific approach to mental health services, and new research can facilitate this process.
- (3) All practitioners and practices of the indigenous healing system (primary health care, traditional healing, school-based counseling and NGOs) must be scientifically evaluated for effectiveness and outcome. Mental health activities should never be assumed to be universally helpful or benign; some practices can produce negative outcomes on traumatized persons.
- (4) Children and adolescents must be provided with science-based mental health services. This requires special attention to their developmental stage, family environment and the unique community settings for their mental health care, such as schools, nurseries and day care programs.
- (5) All mental health services must be culturally appropriate. This means that mental health providers must primarily come from the patient's/client's cultural background, diagnosis and treatment be embedded within the local culture, and that all levels of administration and planning from MOH to local practitioners are sensitive to issues of gender, race, ethnicity and social class.

3.1

Support the formulation of a national set of science-based principles and best practices that are culturally relevant and feasible for all mental health interventions within the local post-conflict environment.

3.2

Implement these scientific principles and best practices widely at national and local levels. This should begin with the scientific training of practitioners within the existing indigenous healing system, that is, primary care practitioners, traditional healers, family members, school counselors, local and international NGOs.

3.3

Encourage the support of future research activities that can provide new scientific information and improve best practices.

3.4

Link all specialized mental health institutions and practitioners to the community-based indigenous healing system. The psychiatrists that exist can maximize their impact by providing consultation-liaisons, technical supervision, training and evaluation support to the existing indigenous healing system.

3.5

Design, implement and link school-based mental health programs (e.g. orphans, child soldiers) to the country's indigenous healing system.

3.6

Monitor and evaluate all mental health services including those provided by international NGOs for their cultural competence, effectiveness, efficiency and ethical standards. This can be achieved by establishing a simple set of evaluation criteria that can be used on a routine basis for monitoring and evaluation.

3.7

All international donors and UN agencies must actively support and allocate resources for monitoring and evaluating the effectiveness of mental health interventions; research funding must also be allocated for mental health research in post-conflict countries to generate new knowledge on prevention, diagnosis and treatment outcomes.

3.8

Recruit local universities and scientists for mental health training, evaluation and research. The current trend where national universities and scientific centers are usually absent from local mental health activities should be reversed.

4. BUILDING AN ONGOING PROGRAM OF MENTAL HEALTH EDUCATION

As a mental health capacity is being built in a post-conflict society, an essential element of maintaining culturally valid, effective, and cost efficient services and activities will be the development of a standardized program of mental health education. Few countries affected by violence are prepared to care for the large numbers of citizens, refugees and internally displaced persons affected physically and mentally by conflict. In many cases, health practitioners have been killed or driven out of the country, and hospitals and clinics have been damaged and destroyed. Building up the mental health capacity of the existing indigenous healing system is the first priority. Maintaining overtime the knowledge and skills of practitioners through a system of continuing mental health education is the second priority. Without continuing mental health education the initial mental health efforts of a national mental health action plan will collapse. Ongoing or continuing mental health education must be multi-disciplinary and multi-sectoral in order to meet the training needs of all practitioners and institutions needed to achieve a successful mental health action plan. National training programs can guarantee

recognition of local social and cultural norms and be based upon available scientific evidence. National training standards can raise the educational bar for all providers including national, local and international agents.

An ongoing system of mental health education has the benefit of providing new and current scientific knowledge and practices. It can also provide a setting for the discussion of ethical problems and an opportunity for mental health practitioners to engage in self-care, and a continuous network of technical and moral support.

4.1

Call together a national meeting of all key stakeholders from the indigenous healing communities, community-based programs (i.e. schools, police) and international and local NGOs to establish continuing mental health educational goals, content and means of implementation.

4.2

- Provide ongoing mental health training programs at three levels:
- (1) Lay persons including family members and survivors;
 - (2) Non-degree training for persons who already hold degrees;
 - (3) Specialized Masters degree training in the health and mental health care of survivors of mass violence.

4.3

Develop new mental health curricula to be introduced into health professional schools, schools of social work, pastoral care, public health and administration, economic development and human rights.

4.4

Provide incentives for ongoing continuing mental health education, including nationally recognized certificates of course completion, academic credit and financial bonuses to those who have completed a program of continuing mental health education.

4.5

Provide opportunities for national and international fellowships (e.g. Fulbright Program) to those experts, scholars and practitioners working in this area.

4.6

Evaluate and control ongoing continuing mental health education at all three levels for scientific quality, cultural validity and efficacy, and long-term national impact. After administering testing, the Ministry of Health should offer a final certificate indicating that a high standard of knowledge and skills has been achieved.

4.7

Evaluate all training activities by international and local NGOs for science-based practices, cultural competence, ethics and cost-effectiveness.

5. COORDINATION OF INTERNATIONAL AGENCIES

The coordination of health and mental health activities in post-conflict countries is often characterized by anarchy. After an initial input of international agents and resources during the complex emergency phase, the recovery phase can lapse into an overall lack of governance of public health activities. Ministries of Health often do not have the human and economic resources, nor the mandate to develop, organize and implement a national system of mental health care. Often international and national efforts are un-coordinated, leading to duplication and the development of parallel systems that can undermine the existing indigenous healing system, and prevent the building up of local capacity. Lack of the most efficient use of limited resources and the implementation of non-scientific, culturally incompetent services and programs is always a threat.

The shift from an acute complex humanitarian emergency to post-conflict recovery will demand a shift in responsibility for mental health from the UN, International Federation of the Red Cross and Red Crescent, and other international actors, to the MOH.

5.1

Identify and organize all international, national and local agencies, donors and practitioners dealing with the mental health recovery of citizens affected by mass violence into a national working group.

5.2

Establish the role of WHO, UNICEF, UNDP and other UN Agencies and international actors in the implementation of mental health activities during the post-conflict phase.

5.3

Integrate mental health activities into health reforms being financed by the World Bank and other major international development organizations.

5.4

Request international support to train MOH administrators in the efficient management of all mental health programs.

5.5

Encourage and organize scientific cooperation between international and national experts interested in mental health. This includes international and national exchanges of scholars between national and international universities, joint research activities, and participation in scientific meetings and congresses.

6. MENTAL HEALTH LINKAGES TO ECONOMIC DEVELOPMENT

The mental health consequences of mass violence are no longer invisible. The *Global Burden of Disease* (GBD) study was the first major scientific overview to establish the economic and development costs of depression. The GBD of depression across nations was ranked fourth in 1990, preceded only by lower respiratory infection (ranked first), diarrheal diseases ranked second), and prenatal diseases (ranked third). GBD data anticipate that by 2020 depression will move globally to rank second, and the disease burden caused by war will be ranked seventh.

While the impact of depression on economic behavior in post-conflict societies needs further clarification, high levels of hopelessness and despair, in some cases affecting more than 40 percent of citizens living in local towns and villages, is having a major negative effect on social and economic development.

In non-traumatized industrialized countries, the impact of mental illness on the labor market, measured in terms of job performance and productivity, has been well established. This research needs to be replicated in post-conflict societies. Preliminary evidence suggests, however, that to date there are significant economic costs of mental illness among highly traumatized civilian populations in the following areas:

- Days of work lost (per week)
- Quality of job performance
- Ability to plan for economic activities (e.g., farming)
- Increase in domestic violence
- Increase in high-risk behavior (e.g., HIV/AIDS)
- Increase in diabetes, cardiovascular disease, and stroke
- Premature death among the elderly
- Negative impact on social capital, neighborliness
- Higher suicide rates
- Poor school performance by children and adolescents

It is now urgent that governments in post-conflict societies focus policies and programs on the linkages between mental health and economic development, while research is further clarifying this relationship.

6.1

Integrate governmental and non-governmental activities between the mental health sector and the labor and social welfare sectors. This includes the coordination of mental health activities with the Ministries of Labor, Education and Social Welfare.

6.2

Promote as a major aspect of the government's mental health activities, job production, job training, vocational training and the development of economic

productivity in the formal and informal work sector. Similarly, technical and vocational training must be made available to school-aged children and adolescents.

6.3

Design, implement and link micro-enterprise activities to the country's indigenous healing system.

6.4

Establish indicators to monitor and evaluate the impact of economic and social development on the mental health status of the general population.

7. MENTAL HEALTH LINKAGES TO HUMAN RIGHTS

Linkage of a mental health framework to human rights is essential. Torture and other forms of human rights violations have a major mental health impact on affected persons, often leading to serious mental illness, including depression, post traumatic stress disorder, chronic alcoholism and drug addiction and psychosis. The emotional development of children and adolescents can be seriously arrested. Survivors of rape and other "crimes against humanity," including the massacre and disappearance of victims have serious mental health implications and demand special treatment approaches. Human rights abuses are also associated with major debilitating life treating illnesses including HIV/AIDS, Hepatitis B and physical damage caused by landmines and other war related injuries. While human rights abuses cause physical and mental illness, the recovery from these illnesses can improve social capital, increase trust among neighbors and reduce hatred and acts of revenge. Strong scientific evidence suggests that the inter-generational transmission of emotional distress can also be reduced, preventing future cycles of mass violence in the next generation.

A human rights priority of post-conflict societies is to promote the health and healing of traumatized people. This mental health action plan recognizes the need for traumatized persons and communities to receive basic mental health care and is consistent with the UN Declaration of Human Rights Article 25 Item 1:

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The international community and national MOHs should be prepared to address the chronic debilitating suffering associated with violence and the strong social benefits that occur by healing this suffering. Once individuals impacted by violence are treated, society as a whole will have a greater opportunity to achieve collective healing, including the prevention of future human rights violations, social justice and reconciliation.

7.1

Integrate governmental, United Nations and non-governmental activities in human rights with the health and mental health sectors. Promote mental health care needs as a component of all human rights projects.

7.2

Promote as a major aspect of all mental health activities a human rights component including concern for the development of social capital, trust and ethnic reconciliation.

7.3

Emphasize basic informed consent and local community participation in all mental health activities.

7.4

Protect all health and mental health practitioners and their patients/ clients from violence; guarantee that no health care practitioner, program or institution engages in violent acts, including torture and other forms of human rights violations.

7.5

Avoid the warehousing, neglect and abuse of the seriously mentally ill in mental hospitals by shifting these patients to treatment in the community in concordance with WHO guidelines and policies.

8. MENTAL HEALTH EVALUATION, RESEARCH AND ETHICS

All Mental Health policies and activities must be subject to evaluation. *Evaluation is simply defined as the systematic use of measurements and comparisons to determine the value or success of a course of action.* It is unfortunate that to date few mental health projects in conflict and post-conflict settings have assessed their relative overall success. It is important to continuously monitor project outcomes over time in order to improve specific mental health strategies and activities. This **Results-Oriented Approach (ROA)**, if universally applied can at minimum guarantee that no persons and/or communities are harmed and at maximum establish a global set of “best practices” that can be culturally adapted and modified in various post-conflict settings throughout the world.

Research has often been considered by field workers and donors a luxury, needless, and an interference with humanitarian aid, and possibly an unethical practice in conflict and post-conflict settings. *Research is the diligent and systematic inquiry or investigation into a subject in order to discover or revise facts, theories or applications.* At the core of all research activities is the empirical testing through scientifically established methods of core hypotheses. Assessment of research results can lead to the utilization of sustainable evidence and culturally based practices. Research studies can also address the effects of health and mental health policies including those related to

human rights and social, cultural and economic development. While some knowledge exists for mental health interventions in conflict and post-conflict settings, little is known about the prevention of violence. Therefore, the urgent humanitarian needs of traumatized populations should not totally override the scientific need for investigation of basic research questions related to all aspects of the health and mental health care of these populations. Otherwise the international community, post-conflict governments and local communities may remain wedded to many mental health policies that are wasteful of money, ineffective, and quite possibly harmful to those served. Similar to the goals of evaluation, research must be oriented to helping post-conflict societies achieve the maximum impact from all mental health policies and activities.

Over the past three decades, research studies of traumatized populations have primarily focused on the mental health sequelae of mass violence with a specific emphasis on measuring the nature and health/mental health effects of trauma events including torture. It is recommended that evaluation and research activities be expanded to include all aspects of the 8 dimensions of this *Global Mental Health Action Plan*. For example, a critical need exists to establish the impact of mental health on development in post-conflict countries (Dimension 6) and the therapeutic power of Truth Commissions (Dimension 7) on those individuals and communities affected by human rights violations.

Widely accepted forms of ethical principles and practices must govern evaluation and research. These principles and practices have been established in the *Belmont Report*, “Ethical Principles and Guidelines for the Protection of Human Subjects of Research” released by the *National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research*. Special Protection must be given to traumatized populations because of their vulnerability due to their exposure (and maybe continued exposure) to lack of safety, a humanitarian crisis, and personal and community violence including torture. The protection in research of traumatized communities and individuals include:

- Proper timing of the research study so that it does not interfere with humanitarian assistance;
- Guarantees that research subjects will not suffer from retribution and retaliation;
- Sensitivity to the socio-political, economic and cultural nuances of informed consent;
- Maximizing the benefits accrued from the research to participants and their communities.

8.1

Develop and implement an evaluation protocol and ongoing monitoring process for all mental health policies and activities. Evaluations need to use culturally validated instruments and a pre-test (ie. before intervention) and post-test (ie. after intervention) model. A comparable control group not exposed to the intervention for comparison is ideal to determine intervention results.

8.2

Expand the evaluation to include not only an assessment of mental health symptom reduction but also an assessment of socio-economic and psychosocial outcomes such as school performance, work, family support, social capital, and engagement in human rights.

8.3

Use ongoing evaluation results to improve the intervention.

8.4

Disseminate final evaluation results to all key stake holders, including subjects and staff, local communities, participating agencies and donors.

8.5

A number of research conditions need to be met including before and during the research:

- Testable hypothesis that can maximize benefit to the traumatized community and their providers;
- Rigorous scientific and culturally valid methods;
- Assessment of the risks and benefits to the community to be studied;
- Competent training of research assistants and staff;
- Culturally valid informed consent process;
- Justification of the use of vulnerable groups (eg. rape survivors);
- Community support;
- Dissemination of results to research participants and their communities.

8.6

Ethical review and approval of all research by the researchers' home institutions, country where research is being conducted, and/or UN agencies administratively responsible for research subjects.

8.7

Establishment of an ad-hoc Ethics Committee which can review in a timely fashion all major ethical problems emerging during the research that may not be clearly covered by existing instruments (eg. Belmont Report).

PROJECT 1 BILLION SCIENTIFIC COMMITTEE

The Action Plan presented in this document was prepared by the international scientific committee of Project 1 Billion and informed by the *Book of Best Practices: Trauma and the Role of Mental Health in Post-Conflict Recovery*.

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