Textbook of Disaster Psychiatry

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Nongovernmental organizations and the role of the mental health professional

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Introduction

A disaster is a serious event that causes an ecological breakdown in the relationship between humans and their environment on a scale that requires extraordinary efforts to allow the community to cope, and often requires outside help or international aid (Lechat, 1990; Noji, 1997). Berren *et al.* (1980) mention five factors that can be used conceptually to distinguish one disaster from another: (1) type of disaster: human-made or natural; (2) duration; (3) degree of personal impact; (4) potential of recurrence; and (5) control over future impact. In natural disasters, a natural hazard affects a population or area and may result in severe damage and destruction and increased morbidity and mortality that overwhelm local coping capacity. Similarly, in human-made disasters such as complex emergencies, wars or terrorist attacks, mortality among the civilian population substantially increases above the population baseline mortality, either as a result of the direct effects of war or conflict, or indirectly through the increased prevalence of malnutrition and/or transmission of communicable diseases, especially if the latter result from deliberate political and military policies and strategies (Salama *et al.*, 2004). In 2000, an estimated 1.6 million people worldwide died as a result of violence, and one-fifth were war related (World Health Organization, 2002b). As Chapter 2 shows, mental morbidity increases too, and varying risk groups need additional attention as well as preventative efforts to alleviate their plight.

This chapter highlights the role of (international) nongovernmental organizations [(I)NGOs]. NGOs are often a key player in both natural and "human-made" disasters. This chapter will focus on mental health professionals who plan to get involved in postdisaster or postconflict work. It addresses psychiatrists, psychologists, psychiatric nurses, social workers, and trainees who are, or who would like to get, involved in disaster work. The crux of this chapter may be well known to professionals from low- and middle-income (LIMA) countries. However, it illustrates various issues that colleagues from LIMA countries may not always be aware of, despite or because of these issues being part and parcel of their daily living environment. I will start with a brief outline of the world of (I)NGOs. Subsequently, the chapter addresses a series of challenges for mental health professionals and how they can prepare for a career in this field. Throughout the text I provide a series of caveats or recommendations for the professional who is preparing to work for an NGO. I asked several colleagues, i.e., Keven Bermudez, Mark Jordans, Wietse Tol, Marianne van der Veen, and Peter Ventevogel, to write some impressions of their work in Afghanistan, Nepal, Sri Lanka, Burundi, Indonesia, and Sudan. Their diaries or week diaries – inserted in boxes in the text – give the reader a sense of and some insight into what life is like "out there."

(International) nongovernmental organizations [(I)NGOs]

In the 1980s and 1990s, the Structural Adjustment Programmes of the International Monetary Fund (IMF) and the World Bank resulted in a reduction of government spending on health and education in a variety of countries. Neo-liberal economic policies further contributed to undermining the already weak governmental sector. To compensate for the decreased service delivery in sectors such as health and education, local and international NGOs tried to fill the gap and create a safety net with special attention paid to vulnerable, marginalized or minority populations. Although the interventions of the IMF often resulted in an overall economic growth, democratic changes and social mobility lagged behind causing increased economic disparities, regional and ethnic conflicts, human rights violations and ecological deterioration. These social changes are risk factors for breeding natural or human-made disasters – as several chapters of this book illustrate. Disasters overstretch existing service delivery capacities, even in high-income countries. Therefore, NGOs are extremely important for developing adequate services for survivors, especially in the emergency phase. The dynamics of the postdisaster context presents NGOs with choices in terms of service delivery models. Both curative and preventive health services can be provided using a horizontal or a vertical delivery mode. In a horizontal program services are delivered through public-financed health systems and are commonly referred to as comprehensive primary care as formulated by the World Health Organization (WHO) and UNICEF in Alma Ata in 1978 and later at the initiative of "Health for All by 2000" (World Health Organization, 1978). Vertical delivery of health services implies a selective targeting of specific interventions not fully integrated in health systems (Banerji, 1984; Rifkin & Walt, 1986).

The past few years have seen increased advocacy for vertical programming for a number of reasons. Vertical programs such as "National Immunization Days" to eradicate poliomyelitis attract donors and political establishments because they show quick results and they are easier to manage than horizontal programs. Vertical programs produce quick and visible results that fit media-hypes on themes such as child soldiers, woman and child trafficking or rape survivors. However, many policy-makers in developing countries see vertical programs diverting human and financial resources away from already resource-constrained health systems (Schreuder & Kostermans, 2001). Moreover, within the current context of health sector reform the tendency is towards health systems strengthening within horizontal programming. In addition, questions remain on the long-term sustainability of vertical programs in terms of outcomes and resources. This is especially important in the field of psychosocial and mental health care, which – despite its proven burden of disease – is less likely to receive the substantial funding that other public health priorities such as tuberculosis, acquired immunodeficiency syndrome (AIDS) or malaria attract (de Jong, 2002). The incentives driving donors and NGOs to provide services may be different (Msuya, 2003). Factors influencing the decisions made by donors on financing programs include the need for quick results to attract political or funding support from their constituents, as the examples of the Tsunami in 2004 and the floodings in the southern part of the United States in 2005 have shown. In making such choices, as a public official or as a donor, there are trade-offs in selecting horizontal or vertical programs. In postdisaster settings a transitional process of emergency through reconstruction to development paralleled by a transition from vertical to horizontal programming is likely to produce the highest level of sustainability. When we started our work it took us many years to develop a sustainable program that was completely implemented and managed by the local NGO to which we handed over all capacity, expertise, management responsibilities, and logistics including transport. For example, in Cambodia with a target population of about 2 million out of a total population of 13 million inhabitants, it took approximately 6 years; in northern Uganda among 170 000 Sudanese refugees, 8 years. After gaining more experience and

being able to use expertise from the same region, we were able to shorten this period to 4–5 years, for example in Burundi where our program covers 4 million people, i.e., more than half of the population. Although we always tried to work toward horizontal integration with government public health services, this proved to be a difficult task because the government mostly did not have the capacity or the motivation to take over the services. This happened even when we offered to hand over the relatively easy task of integrating mental health into primary care including experienced trainers, supervisors, and supplies of drugs. Therefore, we sometimes continued to run the whole program under the aegis of the independent local NGO, or the local NGO continued to manage the psychosocial part while sharing (part of) the responsibility for mental disorders with government structures. In other words, although our final aim was to deliver an integrated horizontal public mental health program, we partially succeeded at the provincial or district level but not at a national level. This also happened in countries where we were the only service provider of community mental health and psychosocial care.

In addition to the government and the NGO sectors, a third, important and highly relevant player in the field, the United Nations (UN), further complicates the dynamic of positioning one's activities between the different actors. UN agencies are manifold, each with different though often overlapping mandates. UN agencies, like NGOs, may be challenged by competition. A mental health professional has to decide where she or he prefers to work. The worlds of the UN and of the NGO both have specific advantages and disadvantages. A mental health professional may be better off at the UN when status and income are important and when (s)he is able to deal with policy formulation, bureaucracy, hierarchy, distance to actual service delivery, and a system where diplomatic considerations may be more important than being qualified for a job. NGOs have their own peculiarities. On the one hand, the advantage is that NGOs are often more flexible, and that the professional has quick access to and stays in close contact with target groups. On the other hand, one has to accept getting involved in many aspects of the work, varying from human resource capacity building to providing care to survivors, as well as management, research, funding, and accountability issues (as illustrated in the boxes in this chapter). In both worlds professional envy and fear of encroachment on one's turf go hand in hand with a compassionate humanitarian drive. A preference to coordinate over being coordinated is rampant, and loneliness may be an important personal aspect of life, whether working at the UN in New York or "en brousse." In the field professional isolation may be an additional challenge. In both worlds mental health professionals can play a supportive role in facilitating recovery of the core adaptive systems that hasten natural recovery from stress for the majority of the population. Where community mental health services are established, the emphasis should be on training local workers to train others and to assume leadership while designing and implementing interventions for families and individuals who are at greatest survival and adaptive risk.

Challenges for mental health professionals who plan to work in postdisaster and postconflict areas

In high-income countries the mental health profession of psychiatry, psychotherapy, psychology, nursing or social work is increasingly driven by evidence-based and manualized treatments, empirically supported treatments (EST), standardized guidelines, or diagnosis-related groupings. Messer (2002) mentions that there probably is no issue currently as contentious in the field of mental health treatment as that of the advocacy and use of manual-guided EST. Strupp (2001) also criticizes the EST development as being based "on a medical model that assumes that a psychotherapeutic treatment can be conceptualized independent of the human relationship in which it takes place. Psychotherapy and psychoanalysis are, however, treatments only in a metaphorical sense and are more akin to educational processes than medical

treatments. Every therapeutic dyad is unique, and research that treats therapy as a standardized, disembodied entity will not contribute to our understanding." This has a particular bearing on postdisaster and postconflict settings that often have a disproportionally large impact in LIMA countries or among immigrant or minority groups in the "West" as the 2001 tragedies in New York and the 2005 tragedy in New Orleans have shown. In these (sub)cultures the collective, the group or the extended family are often more important than the individual, the ego, and the self (de Jong, 2004). The importance of human relationships in these collectivistic (sub)cultures underlines Strupp's criticism about therapy as a standardized disembodied entity. In theory, most scholars and practitioners agree that standardized treatment protocols and guidelines need thorough cultural adaptation, testing, and modification before they can be applied in a responsible way in low- and middle-income countries. Although much has been published on the use of allopathic, academic or "western" methods in culturally nondominant (or "nonwestern") settings, with a few exceptions little has been done to develop treatments based on local coping styles, culture-specific idioms of distress, and culturally appropriate helping methods. Examples of these exceptions are the use of healing, mourning, grief, reconciliation, and cleansing and purification rituals (de Jong, 2002, 2004; Van der Hart, 1983; 1988), the combination of cognitive-behavioral therapy with Taoist or Buddhist philosophy, or the influence of Buddhist approaches on western psychotherapeutic techniques (Bemak *et al.*, 1996; Boehnlein, 1987; Clifford, 1990; Epstein, 1995; Hinton *et al.*, 2004; Kabat-Zinn, 2003; Linehan, 1993; Otto *et al.*, 2003; Teasdale, 1997; Watts, 1969).

The existing evidence-based methods are thus of little avail to a mental health professional who plans to work in postdisaster and postconflict settings. More important even, one paradox of evidence-based medicine is that it may impede the development of creative skills that the mental health professional needs in LIMA countries. The following paragraphs describe several particular challenges, obstacles, and pitfalls that warrant the attention of the future professional and that illustrate the high level of flexibility and creativity of the "disaster mental health professional" (see Table 10.1).

Table 10.1 Challenges for mental health professionals

1. Addressing a multiplicity of causal factors
2. Addressing additional vulnerability factors within a contextual model
3. Addressing the scarcity of mental health professionals
4. Handling the complementarity between allopathic "western" and local healing methods
5. Taking specific characteristics of the survivors into account

Addressing a multiplicity of causal factors

Most armed conflicts are the result of political, economic, and sociocultural processes. Known risk factors for major political conflicts are social and economic inequalities, rapidly changing demographics, lack of democracy, political instability, ethnic strife, deterioration of public services, and severe economic decline (Carnegie Commission on Preventing Deadly Conflict, 1997). Similarly to the development of individual psychopathology in adult or child psychiatry, an accumulation of risk factors or a critical mass of signs increases the likelihood of the occurrence of problems. The sequelae of conflicts are preferably resolved by multilevel, multisectoral public health approaches informed by social sciences (especially anthropology), behavioral sciences, and epidemiology (de Jong, 2002). (Multisectoral or intersectoral means via the sectors of health, education, social, and women's affairs, rural development and the like.)

Most protracted conflicts are related to competition for power and resources, and result in predatory social formations. They affect large, displaced and mostly poor populations, and they are often accompanied by cycles of violence (Hamburg *et al.*, 1999). Conflict-affected countries are among the

most health deprived and access to health services is often extremely limited due to the combination of war superimposed on structural poverty (Lanjouw *et al.*, 1999). This type of conflict requires flexible and sustainable solutions, both functionally and geographically, and may require that paraprofessionals from among the survivors move to other areas together with the refugees or displaced persons when the conflict dictates a continuation of their journey. A similar reasoning applies to natural disasters. Many natural disasters such as landslides, droughts, floodings, typhoons or volcano eruptions affect marginalized groups that often live in inhospitable or dangerous areas. Increasing industrialization, urbanization, decaying infrastructures, and deforestation are among the factors that place many of the world's countries at increasing risk (Quarantelli, 1994). As in human-made disaster, the public health infrastructure is often seriously affected and rebuilding it requires flexibility from the health workers. Consequences of chronic stress at the level of an individual [e.g., in diagnoses such as complex post-traumatic stress disorder (PTSD) or DESNOS] show conspicuous similarities to the prevailing political culture in countries where natural or human-made crises are highly prevalent. The "cultures of fear" in a number of these countries can be characterized by: (1) a sense of personal vulnerability and a feeling of powerlessness, (2) remaining in a state of alert, and (3) the impossibility of testing subjective experience against reality (Corradi *et al.*, 1992; Salimovich *et al.*, 1992). These "cultures of fear" interact with the individual consequences of traumatic stress and result in persistent fears among their populations. The prevailing fear and suspicion weave their way into society and affect support structures, commitments, belief in justice, democratization and human rights. In such a context, some agencies and NGOs work well with local governments. However, the government is often seen as the major cause of the crisis, especially when blamed for neglecting vital infrastructure or when known for its bad governance and human rights violations. In such contexts NGOs often retain critical positions. If the government did not prevent the crisis from happening, does not care about the survivors, or lacks the ability to provide support, the bulk of the relief work falls on the shoulders of the NGOs.

This sociopolitical context has important implications for a mental health professional getting involved in disaster work. A mental health professional designing interventions in crisis conditions should be able to reflect on the social, economic, political, biological, and cultural determinants of mental illness. He or she should be able to collaborate with public health specialists, anthropologists, economists, political scientists, historians, juridical experts, and epidemiologists. Ideally, the mental health professional should at least be acquainted with basic insights of public health and prevention, anthropology, political science, and epidemiology. He or she should be able to judge the (dis)advantages of working in an NGO setting while seeking more close or distant collaboration with the government structures that often contributed to the plight of the survivors. On a more personal level, the professional should also be aware of the impact of chronic sequential traumatization and its interaction with the "culture of fear" on one's own work. Over the past 30 years I have been involved in many post-disaster settings. At times I was seriously confronted with my naive fantasy that my local colleagues would not be affected by the suspicion, the mood swings, the ethnic strife or other sequelae that pervade our literature. And while being regarded as an expert in culture, and always paying attention to the cultural implications of our interventions, I was also confronted with my naiveté in the cultural realm. When we were requested to support an existing NGO (instead of developing our own NGO), I realized that those local NGOs that are able to smoothly interact with INGOs and donors have a large advantage in attracting professional expertise and funding. However, underneath we sometimes were confronted with a local management style that we regarded as feudal, dictatorial or nepotistic. While we always tried to stimulate good governance, democracy and ethnic collaboration by trying to realize these objectives at least in our own organization, we wondered whether we should emphasize our "universal" values or take a

relativistic stance vis-à-vis these peculiarities that did not fit our management and human rights agenda.

Box 1: A day in Burundi

The green hills of Burundi are clouded in white morning haze when we leave Gitega, the ancient capital in the heart of the country. I am with Norbert who recently returned from Rwanda where HealthNet-TPO had him follow a 3-year course programme in psychiatric nursing. Now he is one of only two qualified psychiatric nurses in Burundi. We are accompanied by two general nurses who will be trained by Norbert and me. The road can hardly be called a road and the 90 km takes us three and a half hours. Upon our arrival dozens of patients have gathered for HealthNet-TPO's monthly mental health clinic. Before we start seeing patients we pass by the Provincial Director of Public Health. He is the only Governmental doctor in this province of 350 000 people. He is a young and energetic man, who welcomes us warmly. His desk is full with piles of health statistics that he has to compile for his monthly reports to the central Ministry of Health.

Many of the patients in the mobile clinic have walked for hours to come here and to receive their monthly medication. My task is to see some difficult diagnostic cases and to discuss treatment options with Norbert and the other nurses. The whole spectrum of severe psychiatry is demonstrated that morning: paranoid schizophrenia, severe depression, mania, autism, severe obsessive compulsive disorder and mental retardation. We also see dozens of cases of epilepsy, which in Africa belongs to the realm of psychiatry. Several of the epileptic patients bear visible signs of their illness, such as scars and burns. An old lady even has had her arm amputated after she fell in a fire during an attack. It is upsetting to see such severe disability that could have easily been prevented: since the mobile clinics started in Karuzi this patient has received monthly medication and is free of seizures.

At the end of the morning Daniel passes by. He is born in this area and is one of HealthNet-TPOs psychosocial assistants. During his field visits he encounters many severe psychiatric cases who he refers to the mobile clinic. People with milder psychopathology such as anxiety and depression, often related to psychosocial stress factors, are managed by Daniel himself. Some of them receive individual counseling, but others participate in psychosocial support groups. This afternoon Daniel facilitates a group of HIV-positive teenage mothers in a camp for internally displaced persons (IDPs). Since Norbert seems firmly in control of the mobile clinic I decide to join Daniel. The IDPs do not have refugee status since they remain within the borders of their own country. They are mainly ethnic Tutsis and some Twa (pygmees) who survived attacks by Hutu rebels in the previous decade. Their huts are small and crowded. I wonder how they have survived and lived here for 10 years. The support group takes place in an open field outside the camp. One by one the 15 participants gather, some of them accompanied by a baby or toddler. To my surprise they do not look demoralized and hopeless but rather strong and enthusiastic. Daniel tells me that when the group started, 6 months ago, most of them were too shy and embarrassed to share their stories. The stories are embarrassing indeed: young girls raped by neighbors or soldiers, or who sold their bodies in order to feed their siblings after the killing of their parents. The state of despair has clearly evaporated from this group. During the initial rounds of sharing experiences some of the women share their worries: Will they ever be strong again? What will happen to their child after they have died? The women console each other. In the last 40 min of the session the atmosphere becomes optimistic again after one of the participants proposes the plan to start an income-generating activity to create a mutual fund to help members who are in financial trouble. I am still thinking of this plan when we drive back to Gitega at the end of the day. I will discuss this in our management meeting, since I know that HealthNet-TPO Burundi has just received a small grant to initiate income-generating activities among vulnerable client groups. A small starting capital could really help this group of courageous women.

Peter Ventevogel, psychiatrist, Mental Health Advisor, HealthNet-TPO Burundi, Bujumbura.

Box 2: Jalàlabad, Afghanistan

This region is currently recovering, as the rest of the country, from a quarter century of devastation brought on by multiple wars, amidst continuous threats to its stability posed by opponents to the reconstruction process. This makes it a "hardship context" in the (I)NGO lingo, and, as Psychosocial Advisor for Healthnet-TPO's Mental Health Program in this location, the following transcription of journal entries for three consecutive workdays may reflect

some of the challenges an NGO worker dedicated to mental health concerns may be faced with.

August 28, 2005

I started the week with the typical question, "What will this week bring?" With all that is going on, I still can't consider this assignment anything else than a week-to-week, almost day-to-day affair. Things can shift at a moment's notice for any minor reason, as experience demonstrates. Now we're in the lead up to the Election Day, which at this late hour is still scheduled for September 18, 2005, and what that may bring is still uncertain to many. In terms of work activities, this will mean a slow down as international staff will be inevitably relocated to safer grounds prior to the date. At least this time the evacuation is a planned one, unlike the one which occurred last May, shortly after my arrival on site. Today was our weekly office-based training day, devoted to helping our local psychosocial staff members (two females and two males) build the necessary skills and confidence to run same-gender support groups in the targeted villages. They're entirely new at this but show high motivation to learn, although I also perceive their doubts that such a new way of approaching stress-related problems will take root in villages strongly anchored in traditional ways of addressing these kinds of problems. They are also conscious of the fact that, faced with extreme poverty, many villagers also turn to INGOs with the main expectation that they will provide needed material support, with little time left for those that don't. Fortunately, there also seems to be a wide recognition among the Afghan population that a quarter century of war has inevitably left scars in people's minds. Traditional healing approaches are, presently, not accessible to everyone in the rural areas where we operate or always effective to deal with such issues as arise from war-related experiences. There is, therefore, a chance that our support intervention will progress if adequately introduced.

August 29, 2005

Today we went to one of the three villages targeted in our psychosocial project. What is really tough about going out to the villages, which are no less than an hour away, is getting there given the current state of the roads. The pain has its rewards, however, once you reach the village, where you are invited to sit on a mat in the shade of a thick-trunk tree, remove your footwear, and are served *Chai* before anything else gets underway. This week only a few show up to the group, after a full and rather enthusiastic group last week. We obviously sought explanations, which came towards the end of our stay, when a few group members showed up. The reason: political rallies. Today, the village received a female candidate, and in a region where females are generally not supposed to be seen, this is a real public curiosity. This is not the only thing. The other is that food is served at these rallies. Villagers go to every possible political rally, even in villages different than their own and knowing they will never vote for such candidates, simply because they serve food. There's no way to beat that. One is left to wonder if the elected officials will be those that have served the best food.

August 30, 2005

Today we traveled to another target village, very low profile, as recommended by recent safety warnings due to the insurgent activity in this particular district. Shortly after taking our place in the shade of a tree, group participants started to arrive. The participants welcomed a discussion on the selected topic: the negative impact on general health and well-being of interpersonal conflicts among family and community members. Members of this ethnic group readily acknowledged the gravity of this problem among their own. However, they also expressed a sense of helplessness as these are, in many instances, situations that began generations ago. A participant managed to keep the group afloat by stating that if their ancestors had met in this way, perhaps those conflicts would have been resolved by now, so they better continue discussing this issue unless they wish to pass it down to their children as well. Everybody agreed. So far it follows the usual pattern. Community members turn out to see what is being offered, accept the need for such support, and then whether they continue to participate or not seems to depend on their real disposition to make room for such support in their lives. Many drop out alleging it's not doing enough for them quickly enough. Yet, since no one believes either that such problems can be solved as quickly as instant coffee, one is left with a sense that there's probably more to that demand than what appears on the surface ... A natural reservation to discuss a private issue surrounded with a certain degree of shame? A basic distrust in an alternative approach to their long-standing problems, especially if introduced by a foreign entity? A distrust in fellow-villagers, based on negative past experiences? The more than likely underlying reservations to engaging in such a process only underscore the importance of dedicating equal attention to basic aspects like

these as to the identified major problem that brought the group together in the first place, by helping community members to feel comfortable in each others' presence, to form trusting relationships, to reconstruct their shared memories, and to provide them the chance to freely ask questions about their pressing concerns.

Keven E. Bermudez, MEd, LMHC, Psychosocial Advisor, Healthnet-TPO, Nangarhar Province, Eastern Afghanistan

Addressing additional vulnerability factors within a contextual model

Survivors of extreme stressors such as earthquakes, hurricanes, war, genocide, persecution, torture, ethnic cleansing or terrorism are prone to a range of additional vulnerability factors. Among these vulnerability or risk factors are increased economic hardship, poor physical conditions, a collapse of social networks, marginalization, discrimination, and a lack of acculturation and professional skills fitting the new environment (de Jong, 2002). Most mental health problems of survivors are not determined solely by traumatic events but also by the above-mentioned changes in the social context at the macro, the meso- and the micro-levels. Therefore, public mental health professionals should be able to handle a contextual approach, linking individuals, families, communities, and society-at-large. Trauma needs to be conceptualized in terms of an interaction between these different levels, and not merely as a reified psychological entity to be located and addressed within the individual or group psychology of those affected. Interventions that address one of these levels while taking account of the interaction with other levels are optimal. Interventions should straddle psychological and social domains.

Box 3: Life in a Nepali NGO

Introduction

Nepal has been submerged in a civil war, a conflict that has sharply escalated in the past years. Displacement, torture, unaccounted disappearances and vast losses of civilian lives have become rampant in this Himalayan Kingdom. Mark Jordans is a child psychologist who has been working in Nepal for the past 6 years and is currently working for Transcultural Psychosocial Organization (TPO) with the Center for Victims of Torture, Nepal (CVICT). Together with CVICT he has been working on developing and conducting long-term training courses for psychosocial interventions and implementing psychosocial care programs for victims of child trafficking, for children in areas of armed conflict and victims of torture.

Monday

The day starts, be it the usual 30 min after the agreed upon time, with a team meeting in which resumption of the Post Graduate Diploma course in Psychosocial Interventions is discussed. TPO and CVICT jointly developed and conducted a one-year pilot course in 2004 for a group of students from Bangladesh, Pakistan, and Nepal. The course is the first postgraduate-level, skill-based course in this field of work in South Asia. The meeting focuses on the possibilities of future funding, either through structural support for the training institute as a whole or otherwise on student scholarship bases.

The afternoon is devoted to a national workshop, organized by Save the Children, on psychosocial and mental health issues for children in armed conflict. The meeting brings together some key organizations and touches on the impact of violence on children and the role of NGOs to counter such impact. I have been asked to give a presentation on screening for at-risk youth, which is seemingly well received, albeit by a group of participants that makes following workshops all but a profession.

Tuesday

In the morning a meeting of the Kathmandu Psychosocial Forum (KPF) is scheduled. KPF is an association, co-founded by TPO and CVICT, for organizations and individuals working in the field of psychosocial care and mental health in Kathmandu. It aims to encourage collaboration, technical exchange and professional sharing to increase the general awareness about and professionalism in mental health/psychosocial care. The main agenda points are case sharing and a presentation on a mothers-to-mothers support program for underdeveloped urban populations.

The rest of the day is dedicated to a proposal for Healthnet-TPO International to conduct a five-country psychosocial care program in Sudan, Indonesia, Sri Lanka, Burundi, and Nepal. The project aims to develop a package of interventions, which includes a classroom-based psychosocial

intervention (CBI) as well as youth groups, public awareness and family interventions for children affected by armed conflict. This process of writing has become increasingly frustrating as electricity supply is frequently interrupted (read: loss of unsaved data), which generally indicates heavy monsoon rains or governmental electricity supply control.

Wednesday

Today is the start of a new internship program; a 5-month training course in psychosocial counseling for a group of 12 participants, which is structured through interchanging cycles of classroom learning and supervised practical placements (Jordans *et al.*, 2002, 2003). This summarizes the core ideas of this training program; namely, that it is long term and that it focuses on skills and supervised practice. The first day of any training focuses on introductions as well as doing a pre-test questionnaire to later evaluate the training's impact.

The scheduling of this day is quite unfortunate, as it coincides with a *Bhandha*. Such a general strike, especially when called by the *Maoists*, entails a complete shutdown of the country. It does not hamper our day too much as the training is residential, but the effects of such a day are appalling in terms of economic and social damage for this country.

Before the end of the day I still have to review a planned needs assessment on the public health impact of the war in far-away Jumla district, a survey that should incorporate information from the local traditional healers (*Dhami Jankris*).

Thursday

The morning is dedicated to a clinical supervision class of the students of another ongoing internship course (as described under Wednesday). This course, for 10 students, is in its final month and focuses on psychosocial counseling for children affected by armed conflict. In the daily clinical supervision session (during the practical placements) of two hours the students discuss yesterday's cases. Today one student raises the question on how to deal with an adolescent boy who is reluctant to talk in the sessions but who does indicate that he wants to continue seeing the counselor. Another issue was raised on how to deal with confidentiality when the NGO management asks the counselor to relay client's information.

In the afternoon I continue with making plans for the registration and inception of Healthnet-TPO Nepal. This new NGO aspires to carry out community-based psychosocial care programs in the conflict-affected areas (such as the one described under Tuesday) and should, in collaboration with CVICT, boost the level of expertise in the area. It is within the same vision that Healthnet-TPO Nepal and CVICT will jointly operate the Post Graduate Diploma course (as described under Monday). Besides such strategic planning, the registration proves to be greatly bureaucratic (though luckily not overtly corrupted) and the process of organizational development a challenge – especially due to ever-lacking funding for mental health programs and a visible *brain-drain* by the INGO community or Western countries.

Friday

Today I am facilitating a training course for field monitors of the World Food Program (WFP) on issues of coping with distressing situations. WFP field monitors, working in rebel-controlled areas, are frequently exposed to stressful situations and are also at risk for secondary distress through the stories of their beneficiaries. This short training course was developed to create awareness on the possible psychosocial impact of conflict, self-identification of distress as well as individual coping styles and additional self-help techniques.

Fortunately, this evening is full moon, which is beautifully celebrated with music in the temple courtyard of *Kirateswhor* – a good interlude from NGO life in Nepal.

Mark Jordans, MA, psychologist, working with a Nepali NGO

Addressing the scarcity of mental health professionals

Between 1973 and 1997 disasters caused each year, on average, more then 84 000 deaths and affected the lives of 144 million people, with the majority of victims in developing countries (IFRC, 1999). The ratio of disaster victims in low- and middle-income versus high-income countries is estimated at 166:1, and the ratio of morbidity and mortality in low-income to high-income countries at 10:1 (De Girolamo & McFarlane, 1996; World Health Organization, 2002a).

The bulk of the 35 million refugees and internally displaced people worldwide reside in countries that on average have less than one psychiatrist or

psychologist per 100 000 people (World Health Organization, 2001). Even the 500 000 people estimated to need some form of psychological support after the attack in New York on September 11, 2001 exceeded the service capacity, despite the fact that New York has the highest density of mental health professionals in the world (Herman & Susser, 2003). India, which has suffered from several typhoons and ethnic-religious clashes over the past years, has an estimated 4000 psychiatrists, representing a ratio of approximately 1 psychiatrist for 250 000 people (World Health Organization, 2001). This rate varies hugely between urban and rural areas, and between more developed and less developed states. Thus, in some states the ratio falls to one psychiatrist for more than one million people. The number of other mental health professionals, such as psychologists or psychiatric nurses, is even lower: there is 1 nurse for every 10 psychiatrists and 1 psychologist for every 20 (Patel & Saxena, 2003). With the exception of Singapore, other southeast Asian countries such as Birma, Thailand, Cambodia, Vietnam or Indonesia show a similarly bleak picture. In Africa, conflict and disaster-ridden countries such as Angola, Burundi, Eritrea, Guinea Bissau, Mozambique, Sierra Leone, Somalia and Rwanda have one indigenous psychiatrist, who may even work outside the mental health sector. The availability of psychologists and psychiatric nurses is hardly any better. If available, the majority of psychiatrists and psychologists work in urban areas and do not have access to survivors who in general reside in more peripheral areas. Government expenditure on mental health is extremely low. Whereas the burden of neuropsychiatric disorder is estimated to be 13%, most countries spend about 2% of their health budget on mental health. National mental health plans are an exception rather than a rule and sometimes rather paper tigers demanded by donors or UN agencies. Within this context of disinterest in mental health, local professionals cannot sustain themselves by designing and implementing a public mental health policy. Therefore, they are often obliged to survive in the private sector where a substantial proportion of health care is delivered; some estimates put this at 50% to 75% of all health consultations in countries such as Afghanistan or India (Patel & Saxena, 2003). Psychiatric hospitals put an additional strain on the limited available mental health capacity. Most hospitals are decayed and outdated remnants of the colonial past, and often the quality of care has been found to violate basic human rights (de Jong, 2001; National Human Rights Commission, 1999). Salaries are minimal and even before disaster strikes, many mental health professionals have left their country. For example, war- and tsunami-affected Sri Lanka has 28 psychiatrists, with approximately tenfold that number residing in the UK and 20-fold in the United States. To compound the human resource problem, complex emergencies, insecurity, genocide and terrorism may cause an exodus or even the extermination of intellectuals. The persecution of intellectuals by government, rebel or terrorist groups may become the final blow to the mental health infrastructure as shown in countries such as Algeria, Cambodia, Indonesia, Mozambique or Rwanda. Therefore, as the boxes in this chapter show, human resource capacity building is one of the major tasks of mental health professionals in the NGO and the government sector.

Box 4: Working through a local NGO in Sri Lanka: a difficult start

After 10 years of experience as a psychiatrist in Holland and finishing a Masters in Public Health I got a position with a local NGO in Jaffna, Sri Lanka. The job is an interesting mix of training, supervision in counseling and clinical work, management support, development of community mental health programs and possibly some research.

September 2003 I visited Jaffna for an assessment. Unfortunately it then still took another year and a half before our proposal was approved. Shortly before my departure I was informed that in the mean time two Volunteer Service Overseas (VSO) staff had joined the organization: a social worker with management experience and a clinical psychologist. December 2004 I was ready to go, but my flight was delayed at the last minute because of a visa problem. Two days later the Sri Lankan coastline was devastated by Tsunami and at once my delay felt like a narrow escape.

The NGO Shantiham I work with was established in 1987 to provide psychological help for victims of torture. Over the years the organization has shown tremendous power to survive bombing, shelling, a continuous brain drain, personal threats and displacements. By now it has developed into a training centre for counselors and psychosocial trainers in community mental health. It is a nonreligious NGO, but the present management is formed by dedicated Hindus and is a strongly hierarchical structure following principles that are not always easy to comprehend for an outsider. After Tsunami the NGO was actively involved in providing Psychological First Aid for the affected people. Demands poured in to give training in basic psychosocial principles and trauma reactions to local workers of different national and international NGOs. The available psychosocial trainers and counselors worked nonstop. The two psychiatrists provided supervision, and were involved in organizational issues and handling the many offers of help. Foreign experts and consultants started streaming in, for a short visit to the coast often followed by some training on PTSD and grief.

It is at this stage that I arrive. In the first two months I hardly see my two Sri Lankan colleagues due to their overload of work. For my information I am referred to the two VSO staff. By the end of the first month I have a brief meeting with my main Sri Lankan counterpart. I try to explain what my expectations and ideas are, but we have only 10 min and it will take another month before I meet him again. I use this time to familiarize myself with the organization, the existing mental health facilities and other local NGOs. I get involved in organizing a training for counselors. I discuss the possibility of taking over clinical work to set my Sri Lankan colleagues free for other activities, but there is no money for a translator. I try to write proposals for the offers that are pouring in, but the information I get is too fragmented to make any progress. Computer and email facilities are poor and often failing. Staff of the organization are getting exhausted by the overload of work. Meetings are very much ad hoc and internal communication is poor. Amidst this chaos I try to find myself a position. My presence at management meetings is discussed and agreed upon, which will help me to build up more of a relationship with the management. However, in practice, meetings take place and I am never informed. After confronting the management they promise to inform me next time, but they keep "forgetting." I try to arrange a visit to the Tsunami-hit areas: but again, the car just left or they went yesterday. I express my interest in assisting in their efforts to set up new community mental health programs, but again I am passively being kept out. The implicit message seems to be: first we need to get to know you, before we let you in. It is difficult to grasp the fact that here I am, an experienced professional, in a post-Tsunami country crying out for psychiatrists, and there is hardly any work I can put my hands on.

After 20 years of civil war the Tamil society in the North East of Sri Lanka is showing features of collective trauma. My Sri Lankan colleague listed these features as mistrust and suspicion, conspiracy of silence, deterioration in morals and values, poor leadership, dependency and superficial, short-term goals. I start realizing that, being part of this society, my NGO has taken on many of these features. Apart from the different Asian communication pattern, where true relationships are often more important than truth, I see myself facing a wall of mistrust, disinterest and ad hoc decision making. I have to win the trust of my two Sri Lankan counterparts, who, due to the hierarchical structure, are the key to any activity. However, they are hardly available for any discussion and, if they are, they often say yes, but rarely follow things up. Also, there are differences of opinion between my two counterparts and because I hardly ever manage to see them together I am stuck in the middle.

I am now six months down the line and finally got a budget for a translator, which gives me a voice, ears and some independence. I can now take up the challenge to overcome the suspicion of my colleagues, making it clear that I came as a friend to assist them, not as an intruder intending to take over control of their NGO.

Marianne van der Veen, Psychiatrist/MPH Association for Health and Counseling, Jaffna, Sri Lanka

Box 5: Riots in Jalalabad, Afghanistan

On May 10, 2005, Jalalabad, a provincial capital in Eastern Afghanistan, was the scene of violent eruptions of anti-Western sentiments. HNI-TPO has been present in Afghanistan since 1994.

At the shrine of Mialisaheb in Samarkhel village I introduce two visiting psychologists to the traditional islamic healers who take care of the schizophrenic patients in this sanctuary. It is around 9.30 in the morning. We are waiting for the healer to make us a protective amulet with Koranic verses (one never knows) when my satellite phone rings. It's Munir, our Afghan office manager. He sounds worried. There is trouble in the city. Thousands of people demonstrate against the alleged desecration of the Quran at the American detention center in Guantanamo Bay. The

village mullah offers us refuge, while the office sends us an old rented car to pick us up. It is better to keep a low profile and not to travel with an NGO car in this sitation.

At the outskirts of Jalalabad we get stuck in an exodus of hundreds of cars and rikshaws trying to escape the city. I see thick black smoke above the city. When we hear shooting nearby we seek refuge in the house of Roghman, an Afghan doctor who works with HNI-TPO. Without questioning we are led inside the visitors' room and supplied with cake and green tea. At least for this moment we are safe within the thick walls of this old family house. Outside are the sounds of more gunshots. The incoming phone calls inform us about yet other offices of UN organizations and INGOs that are set aflame. My colleagues come from the guest house to tell me that they are safe too.

When it seems to get quiet again in the afternoon we slip into the car and drive to our house. On the streets we see the remains of burned tires and broken windows, but the angry crowds have dispersed. At home we meet with our colleagues and share the stories of today. We are in continuous contact with our head offices in Kabul and Amsterdam who have arranged for evacuation.

Late afternoon we depart for the airstrip. Expatriates from other organizations tell us that they have lost all their properties. We realize how lucky we have been. When the first rumors of the riots reached the office our staff took all signboards down and removed the dish-antenna from the roof. The hundreds of men who filled the street in front of our office were told by neighbors that there was no NGO here. They proceeded to the nearby UNICEF office which was badly damaged. We are relieved when it is our turn to enter one of the eight-seat planes which shuttle between Kabul and Jalalabad.

After a short flight we reach Kabul and inform family, head office, and embassies about our safe arrival. BBC World and CNN show images of familiar streets in Jalalabad filled with exalted crowds. How could this have happened? HNI-TPO supports a network of more than 20 clinics and hospitals in the province. I never felt unsafe in Jalalabad, and did not notice that people objected to the health and psychosocial work that we did. The Afghans I speak with are ashamed about what happened. They say that the people are stirred up by anti-government elements. It shows me once more how working in Afghanistan is like walking on a tight rope.

Peter Ventevogel, psychiatrist, Previous Coordinator Mental Health Program HealthNet-TPO, Jalalabad, Afghanistan

Handling the complementarity between allopathic "western" and local healing methods

In view of this scarcity of mental health professionals, local populations use health services that are outside the purview and understanding of the dominant medical system. Complementary and traditional medical services are juxtaposed to conventional treatments. Almost half of the populations in many industrialized countries regularly use some form of T (traditional medicine) and CAM (complementary and alternative medicine).[1] Scotton & Batista (1996) assert that "70%–80% of the American public is so dissatisfied with the limited scientific model of current medical practice that they have used alternative healing practices within the last year." There also exists considerable use in low-income countries, ranging from 40% in China to 80% in African countries (World Health Organization, 2002a). Thus, a vast informal healthcare sector exists in all countries, and no comprehensive picture of this sector exists as yet in any country (Bodeker, 2000). In view of the above-mentioned scarcity of mental health professionals, healers provide an important contribution to psychosocial care. From a public health perspective traditional healers often have the advantage that they are easily accessible from a cultural and geographic point of view. For example, in Ghana 1% of the population is engaged as a healer or a shrine-holder. Among the Yoruba in Nigeria, healers form 10% of the adult population in rural areas, and about 4% in urban areas (Ademuwagun, 1979). In Guinea-Bissau there is 1 healer for 475 inhabitants, and in the Philippines and Mozambique there is 1 healer for every 200 people (de Jong, 1987; Northridge, 2002; Tan, 1985). Traditional healers are culturally and linguistically similar to their clients, share the cosmology of their clients, and generally have a holistic approach to healing especially useful to conflict-affected populations who may suffer a variety of traumatic impacts and symptoms, including emotional, psychological, physical/somatic, social and spiritual ones. Many healers work part-time as a healer while

continuing their work in the communities to which they belong.

While more than a thousand quantitative studies on the outcome of psychotherapy have been carried out, there exist only a few studies that purport to evaluate the treatment effects of traditional healing. In comparison with accepted minimum standards of psychotherapy evaluation (Lambert *et al.*, 1998) one can be very critical about the methodology used for the evaluation of healing. Cross-cultural differences exist in disease expression, help-seeking behavior, and the aims of healing practices and treatment. Standardized instruments are useful for evaluating outcomes in relation to standard psychosocial interventions, but they may not encompass local constructions of mental distress, reasons for seeking traditional healing, or definitions of successful treatment, which may be grounded in spiritual cosmologies (Patel *et al.*, 2005). Despite these methodological shortcomings, several scholars found interesting results among healers. For example, Crapanzano's qualitative study (1973) attributes the greatest success to a Moroccan possession cult in psychosomatic and hysterical cases. Finkler (1985) in her study in Mexico concludes that healing attenuates symptoms associated with generalized anxiety or (pain associated with) depression in about 25% of patients. Kleinman's (1980) figures on Taiwan suggest a maximum positive treatment outcome for half of neurotic patients. (However, neither Finkler nor Kleinman provides clear figures about treatment effects for specific categories of patients.) In a later study in Taiwan, Kleinman and Gale (1982) compared a group of patients treated by shamans with patients treated by physicians. More than three-quarters of all patients improved. Regarding the effect of healing in the prevention and treatment of alcohol and drug abuse, Jilek (1994) cites a study that found 1-year post-therapy abstinence rates among opiate addicts ranging from 8% to 35% in the clientele of different healers. A 1-year follow-up study on Naikan therapy among alcohol addicts in Japan found that 49% were abstinent after 1 year (Takemoto *et al.*, 1979). It was found that 44% of chronic alcoholics treated by *curanderos* in Peru had post-therapy abstinence periods of over 6 years (Jilek, 1994). Alcohol abstinence after joining a healing church in Malawi was 2.8 years (Peltzer, 1987).

Compared to allopathic mental health professionals, there apparently exists a high density of healers around the globe. These healers are often the main source of help for local populations. Despite the methodological flaws in outcome studies among these local practitioners, the results of their treatment are not largely discrepant with the results of western therapies, especially in the domain of substance abuse. Mental health workers have to be able to accept the complementarity of the "modern" and the "traditional" healing sectors. They should preferably understand the rationale of some form of collaboration. Convulsions are a domain that may provide an example of collaboration or mutual referral between the allopathic and the local healing sectors. In crisis situations in low-income countries one often sees the classical dissociative phenomena described by Janet or Freud during their time in the Salpêtrière in Paris. In situations of massive stress, a number of people show symptoms of dissociation varying from individual possession as an "idiom of distress" to classical fugue states and epidemics of medically unexplained or mass psychogenic illness with or without psychogenic fits (de Jong, 1987; Van Duijl *et al.*, 2005; Van Ommeren *et al.*, 2001). While setting up services, one has to consider which healthcare sector is best equipped to deal with the high prevalence of all kinds of convulsions, whether neurologic and/or dissociative in origin. Epilepsy has a high prevalence in many low-income countries and, due to a lack of neurological services, is often dealt with by psychiatry. In some areas of Africa and Asia, the prevalence of epilepsy is as high as 3.7%–4.9% and it is often presented to psychiatric and primary healthcare services during or after the help-seeking trajectory through the traditional healing sector (Adamolekum, 1995; de Jong, 1987). Offering treatment to those with epilepsy is a feasible option. A total of 95% of a sample of West African patients

with generalized epileptic convulsions were correctly diagnosed and treated with phenobarbital by primary healthcare workers who received a couple of hours of training; the average seizure frequency decreased from 16 to 0.34 per month in Guinea-Bissau, from 5.33 to 0.22 in Burundi, and from 5.8 to 0.55 in Cambodia (de Jong, 1996, 2004). Dealing with the equally highly prevalent dissociative states, however, often requires sophisticated and psychotherapeutic skills, which – as we have seen – are often not available. In many cultures, adequate management for both groups implies triage of the epileptic patients and referral of those with dissociative states to the local healers, healing churches or possession cults who often are able to deal adequately with various dissociative states in a few individual or group sessions.

To conclude the previous paragraphs, the mental health professional that aspires to get involved in crisis work has to be able to function in a complex sociocultural political context. The large numbers of people with mental health problems after crises surpass the capacities of existing allopathic mental health services. These services are concentrated in urban centers, often provide outdated asylary care, and tend to occupy the scarce human resources that are available. The shortage of human resources is compounded by the geographic distribution of survivors who often reside in peripheral areas that are not covered by modern mental health services. Survivors have recourse to omnipresent local healers whose healing idioms fit with the survivors' idioms of distress and their spiritual cosmology. For the mental health professional this has several consequences. (S)he has to accept to somehow get involved in rehabilitating and deinstitutionalizing old-fashioned asylary care while straddling the development of a public mental program for disaster survivors. (S)he also has to accept that healers provide an important source of help and are part and parcel of coping styles developed in the local culture. This requires a modest attitude, even though in some domains healers may indeed do harm – like the possible transmission of HIV through scarifications (de Jong, 2001; Hiegel, 1996). It also implies some form of collaboration with healers, for example by mutual referrals.

Taking specific characteristics of the survivors into account

In developing services for survivors one has to realize that survivors often belong to a different ethnic or socioeconomic group from those who seek to offer help.

They express their plight in a specific discourse and use a variety of explanatory models. Modern mental health services, even if they are community oriented, tend to exclude specific groups. There are several reasons for this. First, many mental health professionals are not adequately trained to deal with people who have suffered from chronic consequential traumatic stressors. Second, apart from the common stigma of mental disorder, many survivors are prejudiced due to attitudes or taboos in the local culture to seek help, either in the local or in the allopathic healthcare sector. A third reason is that mental health professionals may lack expertise to deal with certain disaster-related problems. An example of a cultural taboo that professionals may find difficult to address is the unspeakable trauma of rape. According to our experience rape sometimes can be mitigated by addressing key figures or with the help of rituals in an African context, but it may be extremely hard to address in for example Asia or the Balkans. Mental health professionals may be reticent to address the issue because they share cultural (counter) transference issues, because they feel a lack of expertise, or because they consider exposure techniques to be culturally inappropriate for such a traumatic event. Another cultural taboo is dealing with perpetrators instead of victims, even though in countries such as Burundi, Cambodia or Rwanda it is hard to differentiate between victims or perpetrators because these roles have often interchanged over time. Another example of a psychosocial problem where our profession lacks expertise in providing (short) treatment is family violence, which has an estimated prevalence of 60%–90% in countries such as Afghanistan or Pakistan.

A fourth reason why some groups are excluded from care is that many survivors are too poor to pay for services or too afraid to travel to access services, for example in countries such as Nepal or Palestine where survivors feel intimidated at road blocks. A fifth reason is that many survivors do not trust or understand the rationale of modern psychosocial or mental health support. As mentioned before, traditional services may offer support to survivors but do not always break through social stigmas, and can be expensive, although within the local cultural context that is an exception rather than a rule. The sixth reason why certain types of problems tend to be excluded from care is the lack of professionals in specialized areas of psychiatry or psychology. Except from a few academic centers in some LIMA countries, the numbers of specialists in the fields of child psychiatry, substance misuse, gerontology, sexuology, or forensic psychiatry are extremely limited. The same applies to local research capacity. A seventh rather logistic and often temporary reason why certain categories of patients are excluded is a lack of consistent availability of drugs, even if they are produced or imported at low costs.

These considerations have consequences for mental health professionals who prepare themselves to get involved in postdisaster work. Most importantly, the mental health professional should develop expertise in cultural psychiatry and psychology and be able to work with explanatory models (Kleinman, 1980). (S)he should be able to apply the explanatory model concept in four ways: (1) to specify semantic networks linking the experience of patients, healers, and other concerned parties; (2) to refer to perceived causes of illness; (3) to look at the "cognitive distance" between patients and practitioners, including allopathic services (Weiss, 2001); and (4) to integrate the explanatory models – both at a population level and at an individual level – into designing an intervention program. In addition, the mental health professional needs to develop expertise in developing services for highly vulnerable groups. Finally, a mental health professional working in these settings must realize that (s)he needs generic expertise in most subspecializations. In postdisaster and postconflict settings comprehensive textbooks of psychiatry, psychotherapy, traumatic stress syndromes, public health, methodology and statistics are important assets.

Box 6: Research capacity building in Burundi, Sudan, Sri Lanka, and Indonesia

I am coordinating a research project on the efficacy of a school-based psychosocial intervention for children affected by armed conflict in four countries (Burundi, Sudan, Sri Lanka, and Indonesia). Following the philosophy of HealthNet-TPO, my focus in this research project has been on capacity building; to train and support research teams in local partner organizations to independently implement research activities. The study consists of a qualitative pre-phase followed by a randomized controlled trial (RCT).

What follows is an account of excerpts of days within a 1-month qualitative research training program, for the research teams in Sri Lanka, Indonesia, and Burundi. In this qualitative pre-phase we are: (1) assessing the public mental health relevance of a psychosocial approach, (2) getting to know context-specific thinking on child development, conflict, and child mental health, and (3) preparing the RCT, through ethnographic techniques. Each day portrayed is preceded by a small background description of the setting and our partner organization.

Sri Lanka

The Tsunami of December 25, 2004 resulted in immense loss of life and destruction of infrastructure. It also reminded the world of an ethnic conflict between Hindu Tamils and Buddhist Sinhalese since 1983. Most Tsunami-affected areas were also conflict-affected areas and many internally displaced people have to face the recurrence of intense loss and fear on top of their involvement in a long history of war. Our long-term partner organization in the North of Sri Lanka, Shantiham, has been providing mental health services, since the start of the conflict, through a community-based approach.

Wednesday June 1: Sri Lankan Training Program – Day 5

It is already a hot day, when I leave my hotel at eight o'clock in the morning. A short bicycle ride reminds me that the city of Jaffna has been at the center of indiscriminate shelling campaigns by the army.

Today we will practice the methodology of *Focus Group Discussions* that we discussed yesterday. A team member volunteers to facilitate and chooses her own topic; "gender inequality in the Jaffna peninsula." A lively discussion follows, in which my translator forgets that he should not participate, but only translate. We appear to have a mixed group of people, with opinions falling in between the extremes of "I would like my wife to be a simple woman. If she works she would disgrace my position as a caretaker," and "We have to emancipate our women! There is too much inequality and suppression." One of the female participants hesitates initially, but eventually joins the discussion. It is this team member who later stops her employment with us, because a very good "proposal" (invitation for an arranged marriage) has come in and her new husband does not like her to work.

After several more practice rounds on different topics, with different facilitators, the working day ends. I decide to go for some running in the Jaffna Stadium, not far from the hotel. The sun sets beautifully over the barbed-wired seaside, and in the center of the running track children are playing soccer.

Indonesia

Our partner organization in Indonesia, Church World Service (CWS), has been present in the country since 1964 providing mainly relief services to vulnerable populations. The Tsunami of December 25 has had the most severe effects in Aceh, a conflict-affected province where CWS is active. The psychosocial intervention for children on which research will take place, however, will be another of CWS' working areas: the islands of Sulawesi. Central Sulawesi has been suffering the effects of a religious conflict between Christians and Muslims since the fall of Suharto in 1998, which has killed 1 000 and displaced about a 100 000 people. Even though there has been a peace deal since 2002, tensions have not subsided, partly because some parties appear to be profiting from the instability in a region rich in resources (cacao, wood).

Monday July 25: Indonesian Training Program – Day 12

Today we have planned the first of several *Community Meetings* to introduce the project and to ask permission for our field research activities. After a one and a half hour scenic drive we reach a village with an impressive church on a hilltop overlooking a monotonous collection of houses painted in Indonesia's national colors. Only later I learn that these houses have been rebuilt for the third time after the village had been completely burnt down twice.

After talking with one of the community leaders during a quick tour of the surroundings, we proceed to the open air community space designated for communal festivities, e.g., the traditional *Dero* dancing for which Central Sulawesi is well known. Here we meet the village headmaster, a teacher, the priest, a midwife, and a group of around 20 farmers, both men and women. They listen intently to our presentations and are happy to provide information and suggestions. The priest thinks it would be good for their homogenous Christian community to have more contact with the Muslim community, in order to facilitate reconciliation and to avoid further bloodshed and damage.

Burundi

Burundi is full of hope after the installation of the first elected president since the massacres of 1993. The head of the biggest former Hutu rebel group is leading a carefully balanced mixed Hutu–Tutsi government. His government's main tasks will be to engage the only rebel group that continues the guerilla warfare (the National Liberation forces or FNL) into peace negotiations and to target the all-pervasive poverty in this East-African nation. HealthNet-TPO Burundi started in 1999 and provides community-based psychosocial and psychiatric services for the population in 11 of Burundi's 16 provinces.

Thursday September 8: Burundian Training Program – Day 17

I start the day with breakfast in an internet café in the capital Bujumbura, which is crowded with United Nations' vehicles and soldiers. On the program for today is a visit to two of our four field researchers who have been practising Key Informant Interviews. We drive north of the capital to Bubanza, into the plains in which the FNL are present. A colleague points out the window and cautiously mentions that "there used to be villages from here to the airport in Bujumbura. People living here were killed during the 1993 massacre or were driven away."

The experience of the field researchers has been interesting. They have met with a nun working in an orphanage, the director of a vocational school, and a guardian in a center for war-affected, orphaned or separated children. We discuss amongst others that it has been difficult to gain trust with the Key Informants in such a short time, and that, to be

able to flexibly adapt questions to different Key Informants, it is important to intimately know and practise the interview.

On the way back to Bujumbura the road is crowded with people on bicycles, some of them carrying big white food aid bags. We stop for food at a market place of a small town, and are quickly surrounded by curious children, some daring to touch my white skin. One of them asks a colleague: "Where did you find a human being like that?" (Wietse A. Tol, CTP Research Coordinator, HealthNet TPO, Ph.D. Candidate, VU Amsterdam)

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NOTE

1 The term "traditional medicine" is used here to denote the indigenous health traditions of the world; "complementary and alternative medicine" primarily refers to methods outside the medical mainstream, particularly in industrialized countries; and "conventional medicine" refers to "biomedicine" or "modern medicine" (see *American Journal of Public Health*, October 2002).