C4C and Global mental health

The urge for a comprehensive, cost-effective and cultural appropriate response to address mental and psychosocial distress

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Introduction

In many societies, mental health issues are linked to marginalization, impoverishment, domestic violence, abuse, overwork, stress or distress, which are increasingly problematic, particularly in terms of health. Mental health constitutes about 12% of global burden of disease with major expectations to rise given the co-morbidity with other non-communicable diseases[1]. People with mental disorders have higher rates of disability and mortality than the average. For example, people with major depression and schizophrenia are 40% to 60% more likely than the general population to die prematurely due to untreated physical health problems (cancer, disease, cardiovascular disease, diabetes or HIV infection) and by suicide. Between 76% and 85% of people with severe major disorders receive no treatment in Low and Middle Income Country (WHO source). At the global level, annual expenditure on mental health is less than US $ 2 per person and falls below US $ 0.25 per person in LMIC, and 67% is allocated to psychiatric hospitals, despite poor health outcomes and human rights violations.

The Comprehensive Plan of Action[2] recognizes the essential role of mental health in achieving the goal of "*health for all*". Based on a lifelong approach, it aims to achieve equity through universal health coverage and emphasizes the importance of prevention by

(1) Strengthening leadership and governance in the field of mental health,
(2) Providing comprehensive, integrated and responsive mental health and social services in a community setting,
(3) Implementing strategies for promotion and prevention in the field of mental health,
(4) Strengthening information systems, evidence and research in the field of mental health

These four main objectives are adopted and included into C4C's strategy as back bone of its mental health related framework.

Mission and Vision of C4C in addressing Global Mental Health

Coming from a health care background, C4C wants to demonstrate that improving health in fragile situations requires a holistic approach that includes attention for the social determinants of (mental) health. People excluded from public services and any realistic development perspective has often lost the use of their own communal resources for change. C4C has developed a way to identify resources and opportunities in fragile settings and among a vulnerable population. Designed projects aim to engage the whole community in a process of identifying local problems, (sometimes hidden) local resources, and local change agents. Thank to this participative approach, projects starts tackling immediate and urgent problems as defined by people themselves. This reinforces community dynamics, strengthens social bonds, and restores healing relationships. C4C is promoting a community based approach, successfully on the basis of cultural knowledge and therapeutic skills.

[1] Global burden of disease 2010 / Prince and all 2007
[2] WHO, *Comprehensive action Plan for mental health* 2013 - 2020

Over these past years, the refugee crisis showed the fragility of the humanitarian system. The financial structure of the humanitarian and development world is changing fast, and remittances are coming up as an important flow of funds between people across countries. Poor people no longer live exclusively in poor countries. Exclusion and inequity are basic problems; religious conflicts and migration are outcomes. Marginalisation goes beyond simply poverty and injustice, happens when people are displaced, fleeing from violence, are disabled and facing unbearable poverty. The major aim of its interventions is to build healthy communities in the broad sense of the word.

Major objective of C4C within this context is the social inclusion of individuals and families while creating a social setting that provides basic security and mutual trust to work together. This includes the social 'repair', building trust, cementing social capital. This might be called conditional trust, a precondition for institutional inclusion to take place, and starts by building groups/networks o (GX – where X is the number of units (families/individuals/other) relevant in a specific setting – e.g. 50 families in Burundi). These groups, once formed, allow for building trust and cementing social capital which in turn allows for all kind of other actions, including financial inclusion through the use of digital technologies. The way C4C builds this conditional trust is based on the "Resource Mapping & Mobilization" (RMM) approach , a capacity-building approach of existing community structures involving local actors to play an active and collective role in finding appropriate solutions to specific problems identified by local stakeholders in different localities[3] (we have a complete protocol of this approach that describes each and every step).

C4Cs Global Mental Health and Psychosocial Support strategy

The global mental health approach of C4C is based on evidences demonstrating:

- Strong associations between mental health related problems and social disadvantage such as exclusion, poverty, violence, gender, conflicts and disasters[4], and the development of the DALY[5] that revealed the real impact of mental disorders as leading causes of the global burden of disease[6].
- Intimate interrelationships between physical health problems and mental health related problems, leading to the slogan "*no health without mental health*.[7]
- The efficacy and cost-effectiveness of a range of psychosocial treatments for mental disorders in low- and middle-income countries (LMICs)[8].

[3] See Resource Mapping & Mobilization (RMM); a reference guide. B. van Mierlo 2016
[4] Lopez A, Mathers C, Ezzati M, Jamison D, Murray C. Washington. *Global burden of disease and risk factors*. DC: Oxford University Press and World Bank; 2006.
[5] Disability-adjusted life year, a metric that reflects the contribution of a disorder or disease to disability and mortality, used in combination with a large and growing body of cross-national epidemiological research
[6]Lopez A, Mathers C, Ezzati M, Jamison D, Murray C. Washington *Global burden of disease and risk factors*., DC: Oxford University Press and World Bank; 2006.
[7] Prince M, Patel V, Saxena S, et al. *No health without mental health*. Lancet. 2007
[8] Patel V, Araya R, Chatterjee S, et al. *Treatment and prevention of mental disorders in low-income and middle-income countries*. Lancet. 2007

- Strong associations between mental health related problems and social disadvantage, especially poverty, violence, gender disadvantage, and conflicts and disasters. This includes the systematic denial and abuse of basic rights of people with mental disorders worldwide[9]

Core of the C4C strategy is to focus on factors that support human health and well-being, in fragile settings through inclusive development. Co-founders of C4C have demonstrated that illness/ disease are not the main relevant points of entry. Most people survive traumatic events without pathological results. Antonovsky (1979) based his reflection on the following paradigm: why some people, regardless of major stressful situations and severe hardships, stay healthy, while others do not? The hypothesis was formulated in terms of General Resistance Resource (GRR), Quality of Life (QoL) and Sense of Coherence (SOC). The SOC refers to an enduring attitude and measures how people view life and, in stressful situations, identify and use their GRRs to maintain and develop their health. The SOC consists of at least three dimensions: comprehensibility, manageability and meaningfulness. These concepts have been used in studies as conducted by the co-founders of C4C and show that individual oriented stress reducing interventions that use appraisal processes, social support, and coping as starting points could be more effective by taking into account the subjective experience of the social context in terms of trust and feelings of mutual support and reciprocity in a community. Findings indicate that affected people may especially benefit from a combination of individual stress reducing interventions and psychosocial interventions that foster cognitive social capital[10].

At Global Mental Health level, C4C contributes to the 'Comprehensive Approach to Human Security', the social inclusion agenda in the Sustainable Development Goals[11] and WHO Comprehensive Mental Health Action Plan as adopted by World Health Assembly in 2013[12]. C4C is an active member the Dutch Coalition of Disability and Development Platform. Over the years, the co-founders of C4C have played a strategic role in the development and dissemination of the WHO Mental Health Gap Action Programme (mhGAP). C4C is also committed to participate in a national coalition in order to ask experts attention for the refugees' problem in Europe, specifically in the Netherlands.

Inclusion of mental health issues in national policies and programs, health systems and other relevant sectors such as education, disability, human rights protection, social protection, poverty alleviation, income generating activities and humanitarian development are important means of addressing the multidimensional imperatives of mental health.

[9] - Patel V, Kleinman A, Saraceno B. Protecting *the human rights of people with mental disorders: a call to action for global mental health.* In: Dudley M, Silove D, Gale F, editors. Mental health and human rights. Oxford: Oxford University Press; 2011. Drew N, Funk KM, Tang S, et al. *Human rights violations of people with mental and psychosocial disabilities: a global emergency.* Lancet. (in press)
Kleinman A. *Global mental health: a failure of humanity*. Lancet. 2009

[10] Tim R. Wind, Maureen Fordham and Ivan H. Komproe. *Social capital and post-disaster mental health*. Global Health Action 2011

[11] EsunaDugarova. *Social Inclusion, Poverty Eradication and the 2030 Agenda for Sustainable Development*. UNRISD

[12] At the 66th World Health Assembly in Geneva, member states of the World Health Organization adopted the final draft of the Comprehensive Mental Health Action Plan 2013-2020.

C4C's paradigm for addressing Global Mental Health

To assume that Western knowledge is universal, whereas indigenous knowledge is local, casts culture as an obstacle and ignores the plight of huge numbers of non-Western peoples mired in bare survivalist ways of life.

- Summerfield-

Especially societies that are characterized by war, ongoing violence, forced migration, and/or natural disasters are in need of adequate interventions that are effective and efficient for large numbers of people that are affected by life threatening events and high levels of insecurity, stress and fear. Taking local understandings and perspectives as a starting point, is based on the belief that the political, historical social, cultural, and economic contexts play a central part in how conflict and adverse events are perceived and how subsequent distress is dealt with.

The discourse in the West about violence, loss, and trauma is focused on the long-term effects of what happens inside the body and the psyche. In other cultures or in neighbourhoods where people of different cultures live, abuses may be perceived not so much as an assault on the 'individual self', but more as destruction of family and group relations and a disruption of the moral order. Relational, socio-cultural wounds then have priority over individual wounds, or are at least of equal importance. In such cases we can speak of psycho-socio-cultural trauma, or collective trauma, trauma which besides healing on an individual level requires healing of the post-traumatic stress in the fabrics of culture and society[13].

The limitations of a trauma-focused psychiatric epidemiology

There are different studies that have been examining the centrality of trauma-focused psychiatric epidemiology (TFPE) within war-affected populations. According to a study[14] that has been assessing the prevalence of psychiatric symptomatology, humanitarian workers that intervene in low-income settings and fragile states are concerned with a number of pressing questions that go well beyond the prevalence of PTSD symptoms in the communities they serve. These people and organizations want to know about local idioms of distress— the particular ways in which psychological distress is experienced, expressed, and understood in specific cultural contexts. They want to understand culturally specific patterns of help seeking behaviour and ways of coping with emotional distress and impaired functioning and be able to identify locally available resources within communities that can promote healing and adaptation. They also want to learn about the health problems and psychosocial stressors that community members identify as most salient and about the impact that other forms of violence (e.g., the structural violence of poverty, institutionalized racism, gender-based discrimination

[13] See presentation MHCE Amman Willem van de Put

[14] Madhur Kulkarni, MS, University of Michigan; Hallie Kushner, MA, University of Chicago. American Journal of Orthopsychiatry Copyright 2006 by the American Psychological Association 2006, Vol. 76, No. 4, 409–422

etc.) may have on the mental health of the population they serve. They want to understand how healthy and impaired psychosocial functioning are defined locally and how these definitions vary by factors such as age, gender, ethnicity, and marital status. Finally, they want to know what sorts of interventions have been shown to be effective in similar settings, so that they can adapt elements of those interventions rather than continually reinvent the wheel or rely on programs that may have intuitive appeal but lack empirical support.

In brief, understandings of distressing events vary between situations, and these variations are very important as to how people themselves perceive and cope with these events. For example, experiences of young people in armed conflict in the Democratic Republic of Congo (DRC) will differ from those of young people involved in armed conflict in Palestine, which in turn differ from the experiences of young people in Syria. The political situations differ; the historical reasons for the conflict differ; the social and communal situations differ; economic factors play different roles; and cultural understandings of the situations differ. These will all affect how young people view themselves and their communities, and how they view their own actions and those of people against whom they are fighting. This in turn will influence how they and their communities deal with the distressing events. Most scholars advocating for a cultural approach to violence -related distress are therefore sceptical of the claims of trauma professionals that trauma is a universal phenomenon, and question whether Western systems adequately reflect experiences of people in other cultures.

An alternative way of looking at trauma

Social constructivism is one of several "critical theories" (Gergen, 1985; Guba & Lincoln, 1994) that have gained popularity during the past few decades. In contrast to logical positivism, with its emphasis on knowing the way things "really are," constructivism emphasizes the socially constructed nature of reality; it shifts attention away from the search for universal truths and toward an exploration of what is considered real within particular social contexts. This does not negate the value of examining the way similar phenomena may occur across diverse settings, but it does represent a genuine shift toward understanding how people in particular cultural contexts understand their world. With specific regard to mental health, a constructivist perspective eschews the search for universally valid definitions of mental health and disorder, focusing instead on exploring the variety of ways psychological well-being and distress are understood and expressed across and within diverse cultural settings.

A constructivist perspective redirects our attention to this meaning-making process and its potentially powerful role in shaping responses, including the development of PTSD, to experiences of violence and other adverse events .This emphasis on the social construction of meaning, and on the active way in which we make sense of life events, has gained recognition among researchers in a number of areas, including research on stress and coping (Lazarus & Folkman, 1984). Interest in appraisals reflects the recognition that human beings do not respond automatically or reflexively to challenging life experiences, including experiences of (organized) violence (Dawes, 1990). This point has significant implications for our how we view the stressors associated with organized violence and their impact on the human psyche.

Culture: definition

People use the word 'culture' in many ways and to mean very different things. In the West, researchers have in the past viewed 'culture' as referring to something that other people have in other parts of the world, without taking into account that every society and community is influenced by culture or cultures (Chakraborty 1991). As Clifford Geertz already observed in 1973: no human community is 'culture-free'. The term has often been understood to refer only to specific customs, practices, food or ways of dressing. However, this definition is too narrow. Culture is about ways of thinking and living. Culture influences the meanings we attach to issues and events, relationships, and interactions, ways of feeling and being in the world. A useful definition is given by Cecil Helman (1994) who defines culture as a "set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relations to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual".

Etic and emic perspectives

It is important to understand how culture influences how people understand and respond to distressing events such as conflict and displacement. These refer to whether one adopts an 'outsider' or 'insider' view of an illness or problem. The etic perspective imposes a way of viewing the world on the illness. Usually this is a Western, biomedical view that tries to make an illness fit a prescribed biomedical category. Behaviour and illnesses are examined from a position outside the social or cultural system in which they take place. The emic approach is the 'insider' perspective, in which the world-view of the people who are ill or distressed is adopted. The cultural and social system in which the people find themselves is seen as central to understanding the illness (Berry et al. 1992). For example, enduring hardship during life has a totally different impact on a person's live when this person believes in karma and reincarnation than for a person that has only one life to makes dreams come through.

Arthur Kleinman (1978), psychiatrist and medical anthropologist, uses the term 'explanatory model' to explain that the patient and the healer may have very different conceptual understandings of the nature of the illness, its cause, and its treatment. For example, the experiences of a returning soldier may be seen by a psychiatrist as symptoms of PTSD. To the soldier and their family, these symptoms may be signs that vengeful spirits of civilians they have unjustly killed may be disturbing them. Whereas the psychiatrist may recommend some form of therapeutic intervention, the family may believe a purification ritual to appease the spirits to be the most effective remedy. The psychiatrist and the family hold different explanatory models of the problem and conflict may arise when communication across these different models does not occur.

Somatization and idioms of distress

The essentialism of the biomedical model has led researchers to presume that core elements of psychopathology are expressed in similar ways across cultures, thereby legitimizing the emphasis on Western psychiatric constructs such as PTSD, regardless of the cultural context. To communicate effectively and intervene appropriately, practitioners must be familiar with locally meaningful mental health constructs and culturally salient explanatory models of suffering. Distress may be understood in spiritual or religious terms and may be expressed in psychosomatic syndromes unfamiliar to Western clinicians. Moreover, symptoms of PTSD may be present, but they may less salient than other manifestations of distress. A common way in which distress is expressed in many parts of the world is somatization: people complain of physical symptoms which are mainly caused by emotional or mental worry, anxiety, or stress. Common complaints are vague aches and pains, headaches, palpitations, dizziness, and weight loss (Swartz 1998). The term 'idioms of distress' has been used to describe specific illnesses that occur in some societies and that are recognized by members of those societies as expressions of distress. An example that illustrates both 'somatisation' and 'idioms of distress' is the term 'nerves'. It is used in many parts of the world to describe bodily pain and emotions: insomnia, fatigue, restlessness, etc., as well as feelings of sadness, tension, and weepiness (Scheper-Hughes 1992). Nerves refer to matters of mind, body, and spirit and no one medical explanation can ever convey the multiple meanings of this illness. One of the main functions of idioms of distress and somatisation is that they convey a wide range of personal and social concerns in a way easily recognizable by other people, who are then alerted that the sufferer may need help.

Local resources and strategies

All communities have resources for dealing with difficulties, illness, and distress. The starting point for any intervention or assistance offered must be an understanding of what these resources are. Local resources and strategies for dealing with distress may vary. One of the most common ways in which people around the world respond when they are distressed is to turn to those around them for advice (Kleinman 1980). Practical advice will often be given about how the problem or illness can be resolved, for example by seeking out a healer, priest, or nurse. Moral support may be given to the person and practical help for overcoming periods of illness may be provided.

Other resources that people draw on may be indigenous healer, diviners, priests, or prophets[15]. Rituals form an important part of healing in some communities[16]. People deal with the realities of their

[15] Honwana (1999) describes how healers and diviners are consulted by people in Mozambique troubled by spiritual problems related to the killing of innocent civilians and to the neglect of the performance of proper burial rites. Reynolds (1996) reports that children who were disturbed by nightmares following the civil war in Zimbabwe were taken to indigenous healers by their parents, and Eisenbruch (1992) observed similar ways of coping with distress amongst Cambodian refugees in the USA.

[16] Wessells and Monteiro (1999) provide examples from Angola where communities use rituals to reintegrate young returning soldiers who were demobilized during a brief period of peace in the country. These rituals were effective in helping most of the youngsters make the transition to civilian life and in facilitating community acceptance of the youth

experience in a dynamic way, constantly negotiating their survival and simultaneously rebuilding their lives[17].

An example; the context of Rwanda

The Rwandan government has recognized the need to address the suffering due to traumatic stress that is widely prevalent in Rwandan society. However, due to lack of appropriate training, staff shortages and time constraints, psychological problems are scarcely treated in regular medical services.

What many people in Rwanda are suffering from is the destruction of social relationships. As Jackson (2002: 39) observes: "Because violence […] occurs in the contested space of inter subjectivity, its most devastating effects are not on individuals per se but on the fields of interrelationships that constitute their life-worlds." Therefore, in the aftermath of the massive trauma Rwanda experienced, one of the major challenges is the re-invention of shattered social worlds. Particularly in places where people have to live together in conditions of close proximity and depend on each other in day-to-day life, a renewed form of social cohesion and the reconstruction of social capital in its entirety are required. Until today many people in Rwanda are suffering from their war and genocide experiences. In addition to their various losses and traumatic memories, they are troubled by poverty and issues related to the impact of the justice system on their everyday lives. For some people these latter issues have been more traumatizing than the preceding political violence, for others these issues were an additional source of trauma[18].

Nowadays it has been recognized not only in Rwanda, that individual trauma counseling and therapy has its limits. First of all, the magnitude of people in countries like Rwanda that are affected by conflicts and traumatic stress related to war, genocide but also by domestic or more structural forms of violence, is rather overwhelming and it would take too much time and manpower to give them individual trauma care. Another, perhaps more important, limitation of psycho-trauma therapy lies in the fact that people in countries like Rwanda particularly suffer from the social wounds that war and genocide has left them with. Both limitations, each for different reasons, call for a more community or group oriented approach to mental health.

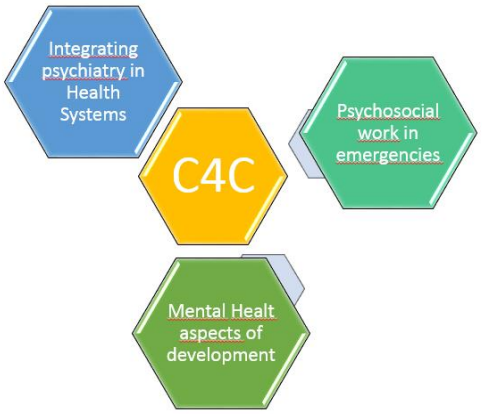
[17] Nordstrom (1997; 189) reported that during her extensive research in many parts of Mozambique over a period of many years she saw no community that had succumbed to chaos, inertia, or destructiveness. Some individuals had, but they were in the minority

[18] Care as a turning point in sociotherapy: Remaking the moral world in post-genocide Rwanda Annemiek Richters, Théoneste Rutayisire & Cora Dekker (medische Antropologie 2010)

C4Cs in practice

The 'mental health' condition is often ignored in aid and development programmes. C4C includes the mental health perspective in a range of interventions. These can be roughly divided in three areas:

1. Immediate psychosocial relief in crisis
2. Integration of mental health in basic health services
3. Adding a mental health perspective in rehabilitation and development interventions in health, education and other relevant areas.
4. The mental health aspects of Sexual and Reproductive Health (SRH)



Ik vind dat het SRHR gebeuren hieronder valt en niet als een apart kopje moet worden gezien. Het mag van mij op nummer 1 komen i.p.v. nummer 4 maar dat is weer een andere discussie . We doen aan SRHR omdat we vinden dat de (psycho) sociale dimensie hiervan vaak ontbreekt

This translates in 4 different thematic angles, ranging from humanitarian relief to social work.

1. Include the sociocultural elements in psychosocial relief in crisis

C4C intervenes in crisis with the specific aim to bridge relief to development. In the planning of emergency humanitarian interventions, it is essential to ensure that community-based Mental Health and Psychosocial Support Services (MHPSS) are widely available. The reason to bridge short term relief to longer term development is because an accumulation of evidences claims that daily stressors have a significant impact on mental health and psychosocial wellbeing, sometimes greater than extremely distressing event. (Jordans, Semrau and Thornicroft& van Ommeren, 2012).

To improve access to care and the quality of services, WHO recommends:

- the creation of comprehensive mental health and social assistance services rooted in the local community;
- the integration of mental health and psychiatric care in general hospitals and primary health care facilities;
- continuity of care among different providers and levels of the health system;
- effective collaboration between formal and informal caregivers;
- Promoting self-care, for example through electronic and mobile technologies.

This approach relies on an immediate to longer term strategy while integrating MHPSS related services gradually into community and health systems.

The objective of C4C when intervening in areas that have been affected by man-made or natural disasters is to ensure that both (semi) professionals and lay people are able and committed to provide

psychological first aid while coordinating efforts with other partners and while developing cultural appropriate materials. In other words, C4C:

- Builds and nurtures a network of lay people and semi-professionals who can provide immediate response, enabling them to continue efforts independently of external aid in a next phase
- Develops materials on different levels while contributing to international guidelines and modules (IASC, mhGAP etc.)
- Strengthens referral pathway while partnering with MoH, attending clusters, task force teams and working groups to advocate for the integration of mental health related services within the Health Care Packages, with a view to long-term government integration.
- Makes itself implementing partner of relief agencies – (e.g. IRC, IOM, , UNHCR, UNICEF, CRS, MSF), create collaboration with agencies like ITM, MDM, Memisa Belgium, WTF, WarChild and others.

2. Integration of Mental Health in basic health services

The co-founders of C4C have been working on the inclusion of mental health in primary health care in about ten countries since 1994. Its staff was partner in PRIME and EMERALD research consortia, international consortia of scientists aimed to improve mental health systems in low- and middle-income countries by enhancing health systems. C4C continues this work and aims to extend these efforts.

Mental Health services need to be integrated in any health system. The current Mental Health GAP action program of WHO is helping to coordinate efforts, strengthening and expanding a continuum of care/support from the community to the health facilities and back down by training and supervising staff at different levels and facilitating task sharing and task shifting.

This layer also includes basic mental health care by community health workers. Intervening on this level asks for a group of well trained and supervised workers who can rely on a comprehensive package of MHPSS related knowledge and extensive practical experience under the supervision of experts in MHPSS. Successful coping with traumatic events is essential to prevent more (physical and mental health) damage and social disruptions due to continuous fear, sleeplessness, nightmares, flash backs, and loss of emotional control. It is also a condition for rebuilding social relationships and restart dialogue based on mutual trust and respect, and to get a better understanding of persisting psychological and/or social problems of vulnerable groups.

Example of good practices

The co-founders of C4C together with a local partner in Nepal and international stakeholders in PRIME (Program for Improving Mental Health Care) and EMERALD (Emerging Mental Health System in Low and Middle Income Countries) consortium has designed mental health programs at three levels (community level, health facility level and policy level. The community level programs focus on user and care giver involvement, engagement with community to reduce stigma associated with mental illness. It also strengthens the existing community structures to better respond to the issues related to mental health. The health facility level program focuses on training primary health care workers on delivery of mental health services to people identified and referred by the community members. The policy level interventions focuses on developing standard training curriculum and

treatment protocol, but also mental health data management system, financing mechanism for mental health services and system for the supply chain management of psychotropic drugs.

3. The Mental Health perspective in LRRD[19] and public health

C4C sees the role of mental health in public health promotion as a neglected issue. Working in areas where no family has been spared from loss and tragedy, it is inconceivable that this given is not appreciated in the planning of rebuilding a new society. People cope with daily challenges which are often so difficult that they would be seen as traumatic in themselves by some western observers. On top of that they have to deliver extra efforts to bring life back to some level of normality that is bearable. This affects programming and project implementation in all sectors.

In the third area of intervention as mentioned below, C4C takes up the challenge of developing public health interventions in areas where people live with these extra burdens. The important idea is to integrate the condition in which people live into project design and implementation. This sounds self-evident but is rarely done. The C4C strategy simple begins with acknowledgement of the special psychological burden people are facing. Translation of this burden in shared understanding of priorities, identification of realistic options, and real participation are the next steps (the RMM approach has been developed on this basis).

People with disabilities

A good example are the people with disabilities. Estimates show that there are at least 600 million people with disabilities in the world, of which at least 400 million live in developing countries and are disproportionately represented among the poor. Disability is a complex concept that associates individual impairment, limitations in activities and functioning difficulties but also restriction in the individual's participation in society[20]. Persons with disabilities in LMIC are more often poorer than non-disabled peoplei, have less access to education[21], employment[22] and healthcare services[23], and face disempowerment and stigma[24]. Persons with disabilities compose a significant portion of the population. In most countries, people with disabilities have historically been stigmatized and denied regarding the opportunities that have benefitted other poor people. They often experience particular protection concerns, including increased exposure to targeted violence, exploitation and abuse, including sexual abuse and gender-based violence. The impairment (f.e hearing problems) facing barriers (f.e overcrowded classroom) and lack of accessibility (f.e no books available to support the oral presentation) become rapidly disability (f.e the child can not follow the lessons)[25]. Individuals

[19] Linking Relief, Rehabilitation and Development
[20] Mont D. *Measuring disability prevalence*. Washington, DC: World Bank, 2007
[21] Mitra S, Posarac A, Vick B. *Disability and Poverty in Developing Countries: A Multidimensional Study. World Development*. 2013
[22] Mizunoya S, Mitra S. *Is There a Disability Gap in Employment Rates in Developing Countries?* World Development. 2013
[23] Trani J-F, Browne J, Kett M, Bah O, Morlai T, Bailey N, et al. *Access to health care, reproductive health and disability: A large scale survey in Sierra Leone*. Social Science & Medicine. 2011
[24] Trani J-F, Bakhshi P, Noor AA, Lopez D, *Mashkoor A. Poverty, vulnerability, and provision of healthcare in Afghanistan*. Social Science & Medicine. 2010
[25] The convention of Rights of people with Disabilities identifies adult , adolescents and children with disabilities as people who have long term physical, mental, intellectual or sensory impairment, face barriers that may hinder their full and effective participation in the society on equal basis with others (UN 2006)

with mobility limitations might develop anxiety and distress due to participation restrictions linked to lack of accessibility as well as to the collective attitudes[26] Similarly, persons with mental illness might develop low self-esteem linked to prejudice and discrimination they face in their community resulting in mood and affect disorders and overall worsening of mental health[27].

Special note on psychosocial disability: when environment becomes a barrier.

Mental health conditions can differ in duration, are often relapsing and remitting in nature, so varying in the degree of disability they cause at any point in time. It is important to note that not everybody who has a diagnosis of a mental health condition would be considered to have a psychosocial disability subscribe to a medical model of mental illness or impairment[28]. Persistent exclusion places people with psychosocial disability at a higher risk of poverty. Conversely, poverty, conflict, poor access to health and social care, and social inequity increase the risk of poor mental health and the vulnerability of people with psychosocial disability. Early research found 90 per cent of people with psychosocial disability were unemployed compared to other people with disability. This may be indicative of the level of dis-empowerment and discrimination experienced by people with psychosocial disability. Likewise, the social isolation experienced by many people with psychosocial disability limits access to social networks which might help facilitate employment (WHO and World Bank 2011)

4. The mental health aspects of Sexual and Reproductive Health (SRH)

Sexual and Reproductive Health and Rights (SRHR) remain violated in developing countries. Reproductive and sexual ill-health is estimated to account for 20% of the global burden of ill health for women and 14% for men. WHO considers unsafe sex to be one of the most important risk factors for health in the world, particularly for girls and women, whose low social status in many parts of the world means they have little control over their sexual and reproductive lives. Therefore, actors such as the WHO, governments, researchers, and NGOs are highly devoted to this topic. According to the UN, "sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system"[29]. This implies that all should be able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. This comprehensive definition includes the main topics of maternal & child health, gender-based violence (GBV), and HIV/AIDS and other sexual transmitted diseases[30]. The UN has these topics high on the agenda in their Sustainable Development Goals (SDGs). SDG **3** targets the *health of the people*

[26] Velema JP, Ebenso B, Fuzikawa PL. *Evidence for the effectiveness of rehabilitation-in-the-community programmes*. Leprosy Review. 2008

[27] Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. *The consequences of stigma for the self-esteem of people with mental illnesses*. Psychiatric Services. 2001

[28] Carroll, A.; CBM Australia; Davar,B.; Bapu Trust for Research on Mind and Discourse Eaton, J.; , CBM International Catherine, R.; , Fiji Youth Champs for Mental Health; Cambri,J. , Psychosocial–Disability Inclusive Philippines; Devine, A.; Vaughan, C. . *Promoting the rights of people with psychosocial disability in development research and programming*, The University of Melbourne, August 2016

[29] UNFPA (n.d.). Sexual and reproductive health. Retrieved January 12, 2016 from : http://www.unfpa.org/sexual-reproductive-health#

30 http://www.sciencedirect.com/science/article/pii/S1049386711001666

and goal **5** targets *gender equality*. By improving SRHR (as described in both goals), steps towards gender equality (goal **5**) are undertaken, as it is known that women, when able to make decisions regarding their SRH, have increased access to their educational and employment opportunities[31].

It has become increasingly clear that mental[32] and physical health are closely linked, influencing each other in powerful and complex ways. Sexual Reproductive Health (SRH) issues are known to have an impact on mental health. These SRH issues concern adverse maternal outcomes (stillbirths, abortions, preference of boys to girls), sexually transmitted diseases, family planning, reproductive tract surgery, sterilization, premarital pregnancy, stigmatization, and infertility. Similarly, mental health issues related to sexuality, childbirth, physical and sexual violence can influence SRH and outcome. According to WHO[33] (see report WHO, 2009), depression is the single largest contributor to years lived with disability in adults. Symptoms of depression and anxiety, as well as unspecified psychiatric disorder and psychosocial distress, are 2–3 times more prevalent among women than among men. There is also considerable evidence that stressful life events, such as reproductive health problems are closely associated with depression and anxiety disorders[34] and can reinforce each other. Such events and problems are more common in the lives of women; in particular gender inequality leads to considerable stress for women. In general the determinants of health are key in appreciating the situation of i) human security, structural violation and Human Rights, ii) limited access to basic services (including Sexual and Reproductive Health) and iii) poverty and social and economic infrastructure. Many problems of women are related to ongoing political instability, war and insecurity, the resultant economic breakdown, traditional beliefs and customs, and high illiteracy rates which encompass a poor knowledge of Human Rights[35]. These are all parts of an overall mechanism that create social environments where family violence and other harmful practices are very likely to occur and continue to exist.

The mental health of women is also closely linked to their capacity to give essential responsive care to their home environment, children and other family members, and therefore any initiative to improve family health must also seek to improve women's mental health. The effects of depression, anxiety and demoralization compromise women's capacity to provide sensitive, responsive and stimulating care. Children of depressed mothers have poorer emotional, cognitive and social development than infants and children of non-depressed mothers especially when the depression is severe and chronic and occurs in conjunction with other risks such as socioeconomic adversity.

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[31] UNFPA (2012). By choice, not by chance: family planning, human rights and development. New York: United Nations Population Fund.

[32] WHO (2010); 'Key components of a well-functioning health system. Geneva, World Health Organization'. The concept "mental health'' should be understood here in a broad sense, it includes severe mental disorders that need medication but also mild depression, anxiety or substance abuse, and psycho-social problems including family problems, hostility, grief, socio-economic problems, problems of women without husband, without children etc, problems that might result in common mental problems.

[33] Mental health aspects of women's reproductive health; A global review of the literature (WHO 2009)

[34] Rates of depression in women of reproductive age are expected to increase in developing countries, and it is predicted that, by 2020, unipolar major depression will be the leading cause of DALYs lost by women (Murray & Lopez, 1996) See WHO report 2009

[35] See survey 'Community Based Psychosociaol Services Nangarhar, Kapsia, Kabul' Afghanistan April 2010

However, as the WHO already concluded in 2009, the inclusion of mental health in SRH programs is until today often lacking. Although the importance of mental health is acknowledge in SDG **3**, there is still a lack of research and evidence in this field, which is essential for the development of holistic SRHR interventions. The World Health Assembly (WHA) underlines this importance, as the convention on mental health in 2013 acknowledges the risk for vulnerable groups, such as women and girls. Especially in fragile states, girls and women are subject to high levels of violence including family violence, physical, sexual and emotional abuse, which affects both their mental and physical health status negatively. Despite these insights, mental health remains, in many countries, at best, a marginal concern.

The specific role of C4C when addressing SRHR related topics

SDGs have been developed for the whole world, but should be adapted to the context in which it is implemented. Looking at Goal 3, C4C related initiatives contribute to goal **3**, by improving health. Relevant targets are: target **3.1** (reduce MMR), target **3.2** (reduce preventable deaths of newborns & infants), target **3.3** (combatting HIV/AIDS and other communicable diseases), target **3.4** (reduce premature mortality by *inter alia* promoting mental health), target **3.5** (strengthen prevention and treatment of substance abuse), target **3.7** (universal access to SRHR-*care services*). The programs furthermore addresses goal **5** (gender equality), by having an impact on target **5.2** (ending all forms of violence), target **5.3** (child/early marriage, female genital mutilation), and target 5.6 (universal access to SRH *rights*).

C4C contributes to these goals by applying a Resource Mobilization and Mapping (RMM) approach, which builds on a reappraisal of existing structures, practices, traditions, and protection mechanisms within the social and cultural context. Effective implementation of programs requires inter-sectoral coordination and agreement among diverse stakeholders on different levels. Therefore, there is active involvement of both community actors and, where possible, governmental authorities at different levels of society in order to contribute to long-term sustainable recovery of health and well-being. The active engagement of women and youth appears to be crucial for the prevention of unwanted pregnancies, GBV, STDs & HIV/AIDS. This participatory and community-based approach aims for local partners and key actors to take over activities or integrate new approaches within their intervention logic.

The RMM approach focuses on the demand side and can be briefly explained as following:

- Networks of local actors (50-100 people) are established at community level
- Key member of these networks and key actors at Commune level receive training in SRHR related issues in order to support initiatives at community local level
- Community Change Agents are selected through these networks; these people mobilize other members of the community to adopt health practices in relation with SRHR, sharing their personal stories
- Selection of the so called “braves” through the established networks; these people focus on SGBV related issues, help victims of SGBV to register themselves and provide basic support
- Members of these networks are invited to participate in discussion (adults and young in separate groups) or socio therapy groups depending of the kind of problems they have
- People with more serious complaints receive individual basic psycho social counselling and/or are referred to more specialized services.

Track Record (Willem YOURS HAVE OT BE ADDED)

The co-founders of C4C have an extensive experience regarding Mental health and sexual and reproductive health programs in [countries]. Projects focused on [topics]. Most important strategies include RMM and socio-therapy. Most important outcomes.

- 2017_Social and Behavioral Change in intimate relationships in Burundi. A Naturalistic Cluster Randomized Trial to determine the efficacy of sociotherapy group intervention in HealthNet's SRHR program in Burundi.
- 2015_MidTerm_Evaluation_SRHR in Burundi: "Birashoboka". To improve the use of SRHR services by improving the knowledge of SRHR among community members, to change behavioural patterns, and to reduce sexual violence. Areas of intervention: i) Adherence to FP, ii) Improved SRH for adolescents and youth, iii) prevention and management SGBV.
- 2015_MidTerm_SHARP: Program in South Sudan whereby the quality and amount of SRHR services and resources are improved, capacity is build, communities are engaged, and research & M&E is conducted
- 2012_Community Systems Strengthening in Afghanistan: a way to reduce domestic violence and to reinforce women's agency; Intervention, International Journal of Mental Health, Psychosocial Work and Counseling in Areas of Armed Conflict. Mierlo, Bibiane van
- 2012_Child mental health, psychosocial wellbeing, and resilience in Afghanistan: a review and future directions. In: C. Fernando & M. Ferrari. (Eds). Handbook on resilience in children of war. Amsterdam: Springer. Ventevogel, P., Jordans, M., Eggerman, M., van Mierlo, B. & Panter-Brick, C.
- 2011_Development efforts in Afghanistan; is there a will and a way? Chapter 8: Mental health and primary care; fighting against the marginalization of people with mental health problems in Nangarhar province. Ventevogel Peter, Hafiz Faiz & Bibiane van Mierlo (
- 2007_ A bold new beginning for midwifery in Afghanistan. Midwifery 23, 226–234. Sheena Currie et. al. .

More information:

http://sanacws.org.za/wp/wp-content/uploads/2015/06/Women-and-Health-The-Lancet.pdf

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