

# **DECLARATION OF COOPERATION**

## **MENTAL HEALTH OF REFUGEES, DISPLACED AND OTHER POPULATIONS AFFECTED BY CONFLICT AND POST-CONFLICT SITUATIONS**

endorsed at the

**International Consultation on Mental Health of Refugees and Displaced Populations  
in Conflict and Post-Conflict Situations, 23-25 October 2000, Geneva**

The Declaration of Cooperation in Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations, is a technical consensus building document in mental health policy, strategies and programme produced by WHO.

It is based on the conclusions and recommendations of seven conferences organised in Europe, on mental health of populations affected by conflict from 1986 - 1998, and further elaborated with WHO's own knowledge and experience and with contributions from Ministries of Health, Ministries of Co-operation, United Nations agencies, humanitarian agencies, non-governmental organizations (NGOs), WHO Collaborating Centres, international mental health associations, international human rights societies, academic and research institutes, international humanitarian relief agencies. Experts in the field from countries in several WHO Regions, including countries in conflict and post-conflict situations also actively participated in the elaboration of the Declaration.

**KEY WORDS:** mental health / programmes / prevention / community-based care/ psychosocial / rehabilitation / emergencies / reconstruction / mental health services reconstruction-development refugees / displaced persons/ war-affected populations / ethics / repatriation / policy / humanitarian emergencies / human rights / genocide.

**Mental Health Determinants and Populations  
Department of Mental Health and Substance Dependence  
WORLD HEALTH ORGANIZATION**

Geneva, January 2001

The tool was conceived in the WHO, Team of Mental Health Determinants and Populations, Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health, by Ms M. Petevi, Technical Officer, Mental Health of Refugees, and elaborated with vast internal and external consultation.

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Special thanks are conveyed to Dr L.H.M. van Willigen, Honorary President, International Society for Health and Human Rights, for her contribution in the development of the document.

Special thanks are also conveyed to Dr G. A. Jacobs, Professor and Director, the Disaster Mental Health Institute, The University of South Dakota, USA and to Dr J. P. Revel, ICRC, Geneva, for their contributions during the review of the document in September 2000.

WHO wishes to thank and to acknowledge the contributions of the following in reviewing the DECLARATION:

*(The names of the experts who in addition to having reviewed, participated at the International Consultation on Mental Health of the Refugees and Displaced Populations in Conflict and Post-Conflict Situations, and endorsed the DECLARATION are underlined)*

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**FIRST TECHNICAL ADOPTION OF THE DECLARATION:** WHO wishes to thank and acknowledge the contributions of the following National Coordinators for Mental Health of Ministries of Health, of NGOs and of the WHO Country Focal Points for Mental Health for their technical review and adoption of the DECLARATION, at the "Second Meeting on Community-Based Psychosocial Rehabilitation in Post-Conflict Countries", Zimbabwe, 21-23 February 2000.

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## BACKGROUND AND METHODOLOGY OF ELABORATION OF THE DECLARATION

The Declaration is the result of a consensus already reached on the themes contained herein through the international consultations enlisted below. These were either convened by the WHO Advisory Group on Mental Health of Refugees, or resulted from international cooperation between UNHCR, WHO and Collaborating Centres, NGOs, and other operational partners and UN agencies. The participants came from most of the continents, from both conflict and refugee host countries. They represented UN agencies, NGOs, academic and research institutions, donors, decision-makers of ministries of health or foreign affairs, and other bodies involved in the protection and assistance, including mental health of populations in conflict and post-conflict situations. They belonged to a wide range of disciplines such as psychiatry, psychology, social work, anthropology, sociology, education, public health, nursing, law, management, and human rights. Most of them combined extensive theoretical knowledge and thorough field experience.

The first step of the elaboration process consisted of condensing the seven hundred conclusions and recommendations of these consultations into seventy. Second step: these were sent worldwide to some fifteen relevant agencies, mental health associations, academic or other institutions, and professionals with a request to review and condense them into twenty principles. Third step: based on the analysis of the responses the draft Declaration was created. Fourth step: the first draft was circulated within and outside WHO to a larger group for review. Fifth step: the feedback served to elaborate the pre-final draft. Sixth step: the Declaration was technically reviewed and adopted at the "Second Meeting on Community-Based Rehabilitation in Post-Conflict Countries" in Harare, Zimbabwe, 21-23 February 2000. Seventh step: the Declaration was presented and endorsed at the International Consultation "Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict Situations", on 23-25 October 2000, organised by WHO for adoption. Eighth step: it will be translated into the five WHO official languages and into as many local languages as needed for dissemination and implementation.

### List of Consultations:

- "Health Hazards of Organised Violence", Veldhoven, The Netherlands, 1986;
- "Health Situation of Refugees and Survivors of Extreme Violence of Organised Violence", Gothenburg, Sweden, 1988;
- "Health Hazards of Organised Violence in Children I", London, United Kingdom, 1993;
- "Care and Rehabilitation of Survivors of Extreme Violence of Rape, Torture and Other Severe Traumas of War in the Republics of Ex-Yugoslavia", Utrecht, The Netherlands, 1993;
- "Ethical Standards in Mental Health Care for Asylum Seekers, Refugees and Displaced Persons", Zeist, The Netherlands, 1995;
- "The Psychosocial Aspects of Repatriation of Former – Yugoslavian Refugees and Displaced Persons", Ribno, Slovenia, 1996;
- "Health Hazards of Organised Violence in Children, II – Coping and Protective Factors", Bergen, The Netherlands, 1998.

**INTERNATIONAL CONSULTATION**  
**Mental Health of Refugees and Displaced Populations**  
**in Conflict and Post-Conflict Situations**  
***From Crisis Through Reconstruction***  
**Geneva, 23-25 October 2000**

WHO convened the *International Consultation on Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict Situations* in WHO Headquarters in Geneva, 23-25 October 2000. Thirty five experts in this field were invited from low and high income countries, including several which are currently in conflict or post-conflict situations. United Nations agencies, NGOs, academic and research institutions were represented. On the first day of the Consultation, the assembled experts were addressed among others by three leaders on the world wide protection and care of refugees.

Dr Gro Harlem Brundtland, Director-General of WHO, stated at the International Consultation, "...We are proposing this document as a contribution towards obtaining international consensus in policy, strategy, and programmes, and as the guiding principle for our efforts in this field... It is our moral and professional obligation to provide the resources, to preserve mental health, restore dignity, and create hope and self confidence for fellow human beings."

Ms Mary Robinson, United Nations High Commissioner for Human Rights, said in her address, "...The number of refugees and displaced persons in the world shames us all. We should be actively seeking ways of alleviating their suffering. I believe that your deliberations relating to the Declaration of Cooperation... which will be adopted at the end of this Consultation will be significant steps forward."

Mr Frederick D. Barton, United Nations Deputy High Commissioner for Refugees, summarized the challenges that lay ahead, "...Like so much we try to do, the immensity of this challenge can seem daunting. The numbers are huge, the locations are multiple, the resources are scarce, the needs are immediate and varied, and our approaches are often compartmentalised and paternalistic. Our certainty is that our work will produce as many questions as answers. As we go about this work, it is vital that we remain focused on those we seek to help, renewing our commitment to their futures. If we do that, we will advance the grand cause of peace - and begin to make progress on these huge mental health problems in conflict-torn places."

Ms Erin Mooney, stressed on behalf of Dr Francis Deng, Representative of the United Nations Secretary - General on Internally Displaced Persons that, "...displacement impacts upon mental health in three major ways. First, there is the trauma associated with the occurrence of displacement, which not only may be induced by but also often involves serious violations of human rights. Second, once uprooted, the displaced suffer a tremendous sense of loss and dislocation, and an uncertain future for them and their children. Adding further strain, displaced persons may find themselves in a discriminatory, even insecure environment, such that they continue to be in a very precarious situation even in their places of refuge."

The expert participants in the Consultation reviewed and amended and endorsed the Declaration of Cooperation in Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations. They called for: (i) its adoption and implementation by all governmental, non-governmental, inter-governmental, United Nations agencies, academic and research institutions; (ii) its inclusion on the agenda of the humanitarian session of the Economic, Social Commission of the United Nations (ECOSOC) in Geneva, July 2001; (iii), its inclusion in the resolution on mental health at the World Health Assembly, 2002; (iv) its integration in the United Nations Office for Coordination of Humanitarian Assistance (OCHA) emergency operations.

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This publication became possible through the financial contributions of  
the Governments of Finland, Greece and Cyprus

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**WORLD HEALTH ORGANIZATION  
Geneva, January 2001**

The Declaration is applicable to populations in humanitarian crisis as a result of persecution, war, and conflict. Given the evolution of the humanitarian relief work, peace keeping and peace enforcing operations, increasingly, humanitarian protection and assistance is extended to besieged and non-displaced populations. Therefore, in order to facilitate the reading, the comprehension and use of this document please note that the following terms as used herein include or mean the following:

**"HEALTH is a state of complete physical, mental and social well-being and not merely the ABSENCE of disease or infirmity."**

*WHO Constitution*

**"A REFUGEE is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country."**

*1951 Convention Relating to the Status of Refugees*

**"FORCIBLY DISPLACED POPULATIONS BY CONFLICT" include: asylum seekers, refugees, internally displaced, repatriated persons, and other non-displaced populations affected by persecution, war and conflict.**

**"CONFLICT" as used herein includes: war, civil war, conflicts (ethnic, military and religious), post-conflict, other unstable and violent situations and complex emergencies.**

**The Declaration is also applicable in response to GENOCIDE.**

# DECLARATION OF COOPERATION

## MENTAL HEALTH OF REFUGEES, DISPLACED AND OTHER POPULATIONS AFFECTED BY CONFLICT AND POST-CONFLICT SITUATIONS

### INTRODUCTION

1. Conflicts subject people to frequent and gross human rights violations. New patterns of violent situations, coupled with shortcomings in the international legal regime, and lack of respect for legal standards, exclude millions of people from humanitarian protection and assistance. The most vulnerable are under greater physical and psychological pressure. These include, but are not limited to: children; unaccompanied minors; orphans; children heads of households; the physically and mentally disabled; the chronically mentally ill; elderly persons alone; survivors of organised violence, torture, sexual violence; detainees; and prisoners of war. Their special needs should be addressed. Women are increasingly the targets of harsh persecution, while paying a very heavy price due to the family, and social dislocation and the added responsibilities which result from the situation.
2. This Declaration is intended to serve as a working instrument. It provides a framework to achieve increased consensus and cooperation in operational models, including policy strategies, and programmes. It is aimed at promoting evidence-based, holistic and community-based approaches that are effective and which can be implemented rapidly.
3. Given the magnitude and the nature of the problem, the fact that the reactions of populations affected by conflict are expected reactions to extraordinarily abnormal situations, and the shortcomings of other models, community-based psychosocial approaches are recommended. They must be sensitive to gender, to culture, and to the context. They must be empowering, mobilizing and supporting the refugees and other populations affected by conflict to continue taking responsibility for their lives and strengthen social cohesion within the communities.
4. The Declaration is consistent with the existing international instruments related to humanitarian protection and assistance, to human rights, to children, to women, and vulnerable groups.
5. The World Health Organization calls upon all governments, organizations and institutions to adopt and implement the following concrete steps, in taking up the challenge to prevent and reduce mental disorders and mental health problems, to restore hope, dignity, mental and social well-being, and normality to the lives of refugees, displaced and other populations affected by conflict.

## PREVENTION AND RESPONSE

**Article 1.** It is widely recognised that conflict, human rights violations, and forced displacement have a substantial negative impact on the physical and mental health of millions of people. This is a serious public health concern, requiring priority action from the emergency onwards to address the consequences of trauma, to prevent personal and collective psychosocial disability and dependency, and to contribute towards preventing future conflicts.

**Article 2.** It is established that the majority of forcibly displaced populations are women and children. The physical safety, health, psychosocial protection, and healthy development of children must be given priority action. Mental health policies and programmes must be well adapted to the context, be sensitive to the different needs of women, to their culture, must avoid stigmatization and re-victimization. It is recognised that women with special needs must receive due protection and support, whilst a balance must be maintained with the significant needs of other groups.

**Article 3.** Local regional and international policies and plans should pursue immediate and long-term mental health capacity-building, based on models that respond to the needs of the greatest number of persons affected by conflict, without neglecting those with special needs. Therefore, community-based, psychosocial, phase-specific, cultural and gender-sensitive programmes must be given first priority when establishing or reconstructing mental health care systems. They should bridge in a coherent way emergency response to development. Specialised clinical interventions responding to individual needs are limited. They must be balanced, because they respond to the needs of a few, may possibly become stigmatizing, tackle problems in isolation, are expensive and non-sustainable. In addition to providing treatment mental health professionals should serve as a resource for early detection of people in need of urgent care, for capacity building, on the job support, monitoring, and coordination.

**Article 4.** In national services, in camps and settings for displaced populations personnel of the primary health care system should be mobilized and be given basic training in mental health, including sensitivity to culture, context, and prejudice. Human resources available within communities affected by conflict, such as camp leaders, staff of national, regional, international, governmental, non-governmental and UN agencies and volunteers must be included in this training. Also, staff of other sectors such as social welfare, education, employment, police and justice, relief project managers and workers, relevant administrators, local press and mass media must receive this training. This should occur in all emergencies, as soon as the peak of the survival crisis starts yielding. Mechanisms must be established enabling these professionals to work together to improve mental health care and psychosocial activities, to develop a well coordinated sustainable, multi-disciplinary, and multi-sectoral mental health response.

**Article 5.** In the emergency phase, a rapid assessment of initial mental health needs and available resources should be carried out in collaboration with local authorities, professionals and concerned groups to define priorities and to identify: available psychological, social, and economic resources; the severely mentally ill and other vulnerable groups; community and environmental aspects. This will help design and implement adequate programmes.

**Article 6.** In the long-term phase consolidation, replication, and scaling-up of the most useful programmes should be pursued with the necessary adaptations to the various situations. In the reconstruction phase mental health of refugees and other populations affected by conflict must be included in continuing education of essential personnel and in the curricula of relevant secondary and in university education. This is very important for teachers, social workers, nurses and post-secondary vocational training, midwives, doctors, psychologists, psychiatrists, and other service providers. Efforts must be made to integrate external educational resources into existing local and national systems of

education whenever feasible. Establishing parallel systems of education must be avoided they complement the local systems on a temporary basis.

**Article 7.** Cooperation and partnerships between governments, international, non-governmental organisations, United Nations agencies, the communities affected by conflict and the host communities, scientists, donors, health authorities are essential for good mental health practice, cost-effective and sustainable programmes. Increased information gathering and sharing among agencies must prevent duplication of assessments and programmes. Use of the comparative advantages of agencies should be emphasised to decrease costs, competition, and delays, to limit the risk of re-traumatising the communities concerned, and to accelerate implementation of response.

**Article 8.** Information on the rights of people, and on the meaning of the psychosocial consequences of violence, should be provided to the populations affected by conflict and to the host communities through ad hoc mass media campaigns and other activities. Access to communications with family and relatives and to family reunion must be facilitated, because these are very effective methods in promoting mental well-being, in reassuring people, especially children. Access to interpretation should be guaranteed when refugees and displaced persons are dealing with authorities, various services, or agencies.

**Article 9.** For immediate local capacity-building the following summarises the critical activities to pursue in mental health and other social sectors by local and international bodies:

- rapid assessment of mental health needs and available resources; (1)
- training of trainers for health, mental health, and other workers involved in protection and assistance, who would multiply knowledge and skills; (2),(3)
- in-service training, supervision, support, monitoring, and evaluation;
- workshops providing technical support in the design, planning, monitoring and evaluation of mental health projects;
- mechanisms for coordination of activities;
- awareness and information campaigns;
- creation of mobile mental health teams where appropriate;
- support appropriate existing activities among the community affected by conflict, within national services, NGOs, and UN agencies;
- protection of the local and expatriate personnel working in conflict areas, who are at risk of violence for expressing their opinions, for being neutral, and for being perceived as potential witnesses is critical. Their agencies should provide guidelines and mechanisms to protect and prevent risky behaviour. This should include prevention and care for secondary traumatization and burnout.

**Article 10.** In situations of prolonged conflict, camp life, displacement, or repatriation, national policies and plans should be elaborated to contribute to the continuity and coherence of achievable goals in psychosocial rehabilitation and to decrease dependency. The participation of the community affected by conflict in the planning and implementation of rehabilitation programmes is essential.

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1. Ref: Orig. English “Rapid Assessment of the Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations and Available Resources”, Ref:WHO/MNH/MHP/99.4 Rev.1;  
2. Ref: WHO/UNHCR Mental Health of Refugees, WHO, 1996;  
3. Ref: “WHO Mental Health of Refugees, Displaced and Other Populations Affected by Conflict ” Training the Trainers” Module ( Available in English, Russian, French languages)

## SURVIVORS OF EXTREME VIOLENCE

**Article 11.** Survivors of torture and sexual violence should be provided with physical protection and legal advice unconditionally. They should also be provided with the necessary safe physical and psychological environments that will enable them to talk about their experiences if they choose to do so. Medical, psychological, emotional, and social support should be given to survivors of extreme violence with the accepted professional ethical code of confidentiality. All interventions used in these cases should be sensitive to gender, to their cultural and political contexts. Those detained in concentration camps, prisons, and similar settings should be given first priority and full attention.

## WOMEN

**Article 12.** Interventions in mental health, education, employment, and socio-economic support should effectively empower all conflict-affected women to play an active role in organising their lives, in self-sufficiency, and in the reduction of dependency. Such efforts are crucial for women in the high-risk groups such as: widows; pregnant women; single mothers; girls who are heads of families; and survivors of organised violence, torture, sexual, and domestic violence. The principle of equal rights must be applied.

## CHILDREN AND ADOLESCENTS

**Article 13.** In full respect of the best interest of children and adolescents, and the *Convention of the Rights of the Child*, and other internationally recognised conventions and instruments, and because conflict, forced displacement, family and social disruptions are serious dangers to their psychosocial development and well-being, mental health support should be an integral part of their protection, health care and education. Female children face the risks of both children and women. Enrolment of children in military or paramilitary forces must be forbidden. Demobilised child soldiers should receive equal care as other children, although initially they might require special rehabilitation programmes.

**Article 14.** Early family reunion, access to communication with absent family members, support of foster families, and care by peer groups should be implemented from the emergency phase through repatriation as a matter of priority. Furthermore, personnel providing mental health care, education, social welfare, recreational, cultural, sports and other activities should centre their efforts on:

- physical, mental, and social well-being of children;
- prevention of institutionalisation;
- promoting respect for human rights;
- fostering abilities to cope and resilience;
- attending to the special needs of families with children as heads of household;
- prevention of violence against and among children and adolescents;
- prevention of delinquency and other anti-social behaviour;
- prevention of substance abuse;
- prevention of sexual violence and exploitation;
- prevention of family and school drop-outs;
- prevention of harmful and exploitative labour;
- organization of cultural, creative and recreational activities;
- introduction of mental health and psychosocial activities for children in educational and other settings
- introduction of conflict resolution activities.

## LOCAL INTEGRATION

**Article 15.** Low income asylum countries, which are willing to offer long term local integration or citizenship to refugees, on an individual basis or as a group, should be provided with technical, material and financial resources to facilitate their smooth integration and to prevent prejudice against national populations. Integration should be voluntary.

## REPATRIATION

**Article 16.** In the elaboration of post-conflict mental health policies and programmes, policy-makers must take into account the possible conflict of aims in promoting return, recovery, and reconstruction. Realistic transitional objectives must be developed to avoid overburdening physically and mentally exhausted and traumatised populations with unduly ambitious goals.

**Article 17.** In so far as it affects adversely the lives of refugees and other displaced persons, their situation must not be normalised. For all refugees and displaced persons, voluntary repatriation is not only a right but is essential and must be facilitated in all possible ways. Forcible repatriation must not be carried out. Whether they remain in a war-torn country or flee to exile, most of them sustain or witness atrocities, which profoundly affect them, their families and society. Because return includes a search for national reconciliation in a changed and impoverished country, there is a risk of traumatisation, so hasty individual or group repatriation must be avoided. Repatriation operations must be well coordinated between countries of asylum and origin, UN agencies and non-governmental organizations, with special attention to vulnerable groups. Efforts must be comprehensive and equitable to prevent further damage.

**Article 18.** Repatriation programmes should include appropriate preparation of both receiving and the refugee communities to prevent discrimination, revenge and acts of violence against each other. They should also include coordination and implementation of mental health programmes for the chronically mentally ill and the traumatised. All precautions must be taken to avoid unintentional exclusion of the most deprived and of people in vulnerable groups.

## ETHICAL CONDUCT

**Article 19.** Humanitarian relief agencies, the press, mass media, the staff of academic and research institutions, health and mental health professionals, and others working in war zones and other conflict situations should adopt and follow codes of conduct and ethical standards founded on the same principles that govern professional practice in their own countries. At the same time they must be sensitive to the cultural norms of the country in which they work. Individuals who work independently should do the same. Compliance should be promoted through training and other effective means. This will prevent further damage, stigmatisation, exploitation or breaches of confidentiality, which may result from the dependency of the refugees or the communities, or because they belong to a vulnerable or to a socio-cultural or political group different from that of the researcher and service provider. The prevention of re-traumatisation is essential. Agencies must also be responsible for preventing traumatisation as well as providing support and care for their personnel. Solutions for ethical neutrality must be sought. Research must be directed towards the benefit of the affected populations. The ethical standards of the Helsinki Declaration must be followed.

**Article 20.** Governmental and non-governmental funding sources, United Nations agencies, international organizations must ensure equity in the allocation of financial resources for mental health care and psychosocial rehabilitation of refugees, displaced and other populations affected by conflict.

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