RAPID ASSESSMENT OF MENTAL HEALTH NEEDS OF REFUGEES, DISPLACED AND OTHER POPULATIONS AFFECTED BY CONFLICT AND POST-CONFLICT SITUATIONS AND AVAILABLE RESOURCES

This document is a technical document on the Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations and Available Resources (RAMH), jointly developed with the International Federation of Red Cross and Red Crescent Societies, and the Disaster Mental Health Institute, The University of South Dakota, USA, and further elaborated with contributions from Ministries of Health, Ministries of Cooperation, United Nations agencies, Humanitarian Agencies, NGOs, WHO Collaborating Centers, international mental health associations, international human rights societies, academic and research institutions, international humanitarian relief agencies, and with the participation of experts from countries in several WHO Regions, including countries in conflict and post-conflict situations. It is the final version of the document endorsed at the "International Consultation on Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict Situations", Geneva, 23-25 October 2000.

KEY WORDS: mental health/ community-oriented assessment/ humanitarian emergencies/ resources/ refugees/ forcibly displaced persons by conflict/ post-conflict/ mental health care.

Team of Mental Health Determinants and Populations
Department of Mental Health and Substance Dependence
WORLD HEALTH ORGANIZATION
in collaboration with
International Federation of Red Cross and Red Crescent Societies and
The Disaster Mental Health Institute, The University of South Dakota, USA

Geneva, January 2001

The tool was elaborated under the technical guidance of Ms M. Petevi, Technical Officer, Mental Health of Refugees, in collaboration with Dr R. Billington, Former Team Coordinator of Mental Health Promotion, Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health, WHO Geneva. This document is based on the field experience of the authors, on a thorough critical review of articles and books on the topic (of which 200 are in an annotated bibliography), and on the participation and contributions of the reviewers.

AUTHORS:

Ms Mary Petevi, Technical Officer, Mental Health of Refugees, World Health Organization;
Dr Jean Pierre Revel, Former Senior Officer, Relief Health, International Federation of Red Cross and Red Crescent Societies (IFRC), currently in ICRC;
Dr Gerard A. Jacobs, Professor and Director, Disaster Mental Health Institute, The University of South Dakota, USA.

ACKNOWLEDGEMENTS

This work would have not been completed without the substantial contribution of Drs R.P. Quevillon, T.L. Elliott, and G. Reyes, DMHI, USA. The contributions of J.V. Boero, M.D. Hiller, E.K. Johnson-Jimenez, K.L. Le Beaux, and S.E. McCaslin of the DMHI are gratefully acknowledged.

WHO wishes to also thank and to acknowledge the active participation and contributions of the following in reviewing this document. 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 RAMH, are underlined:

Dr F. Agani, Department of Neuropsychiatry, University Clinical Center, Kosovo; **Ms U. Agomoh**, Prisoners Rehabilitation and Welfare Action, Nigeria; **Dr F. Baingana**, Mental Health Specialist, The World Bank, USA; **Dr A. Baker**, Professor, Birzeit University, Palestine; **Prof. C. Ballas**, University of Athens and Advisor, Ministry of Health, Greece; **Dr H. Bamber**, Director, Medical Foundation for the Care of Victims of Torture; **Dr T. Baubet**, Médecins Sans Frontieres, France; **Ms L. Bremer**, Crisis Prevention Center, the Finnish Association for Mental Health, Finland; **Dr E. B. Brody,** Former Secretary General, World Federation for Mental Health (WFMH), USA; **Dr M. Dualeh**, Sr. Public Health Officer, Office of the United Nations High Commissioner for Refugees (UNHCR); **Dr S. Ekblad**, Chair, International Committee for Refugees and Migrants, WFMH, Sweden; **Dr M. Elmasri**, Algerian Society for Research in Psychology (SARP), Algeria; **Dr S. Fernando**, University of Kent and University of North London, U.K.; **Dr C. Garcia-Moreno**, Evidence and Information for Policy, WHO; **Dr A. Griekspoor**, Emergency Humanitarian Action, WHO, Switzerland; **Dr E. Hauff**, Deputy Secretary-General, World Association for Psychosocial Rehabilitation; **Dr P. Hypsier**, WHO Representative, Sri Lanka; **Mr R. Jayasinghe**, Program Manager, Mental Health of Refugees, Ministry of Health, Sri Lanka; **Dr J. de Jong**, Director, Transcultural Psychosocial Organization, Netherlands; **Dr M. Kastrup**, World Psychiatric Association (WPA), Denmark; **Mr N. Khaled**, SARP, Algeria; **Dr A. M. Kos**, Slovene Philantropy, Slovenia; **Dr G. Labellarte**, Italian Psychiatric Association, Italy; **Dr P. Lahti**, President, World Federation for Mental Health, Finland; **Mr J. Lavelle**, Director, International Programmes, Harvard Programme in Refugee Trauma (HPRT), Harvard University, USA; **Mr J. C. Legrand**, United Nation's Children's Fund, USA; **Dr I. Levav**, Former WHO Regional Mental Health Advisor, PAHO; **Dr B. Lopes Cardozo**, Center for Disease Control and Prevention, USA; **Dr S. Malé**, Sr. Public Health Officer, UNHCR; **Dr C. Mandlhate**, Regional Mental Health Adviser, WHO Africa; **Dr J-C. Metraux**, Director, "Appartenances", Switzerland; **Ms P. Mezzetti**, Office of the United Nations High Commissioner for Human Rights (UNHCHR), Switzerland; **Dr R. Mollica**, Director, HPRT, USA; **Dr E. Nahim**, National Coordinator for Mental Health, Ministry of Health, Sierra Leone; **Mr L. Ndahiro**, National Coordinator for Mental Health, Ministry of Health, Rwanda; **Dr F. del Ponte**, Senior Medical Advisor, Swiss Disaster Relief Unit, Federal Department of Foreign Affairs, Switzerland; **Mr F. Quesney**, Psychosocial Focal Point, United Nations Children's Fund, USA; **Dr N. Sartorius**, Former President, WPA, Professor, University of Geneva, Switzerland; **Dr E. Seheye**, National Coordinator for Mental Health, Ministry of Health, Burundi; **Dr H. Sell**, Former Regional Mental Health Adviser, WHO Regional Office for South-East Asia; **Dr B. Sharma**, Medical Director, Centre for Victims of Torture, Nepal; **Prof. D. Somasundaram**, University of Jaffna, Sri-Lanka; **Ms B. Stambul**, Medecins du Monde, France; **Dr N. Sveaass**, Secretary General, International Society for Health and Human Rights; **Dr L.H.M. van Willigen**, Honorary President of the International Society for Health and Human Rights, Netherlands; **Dr L. Weisaeth**, Division of Disaster Psychiatry, University of Oslo, Norway.

Portions of this document were adapted from *Rapid Health Assessment Protocols for Emergencies, Emergency and Humanitarian Action,* (1999), Geneva: World Health Organization.

INTERNATIONAL CONSULTATION "Mental Health of Refugees and Displaced Populations in Conflict and Post-Conflict Situations"
From Crisis Through Reconstruction
WHO 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, on 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 four leaders in the worldwide protection and care of refugees.

Dr Gro Harlem Brundtland, Director-General of the World Health Organization told the assembly of the International Consultation,

"... To address the mental health needs of large populations, we need definite strategies and plans. Ad hoc arrangements and improvisations in response to each emergency will no longer be acceptable. Specific management ability, strong field experiences and evidence-based approaches are required… WHO strongly recommends the establishment of community-based mental health care from emergency through reconstruction. Earliest integration of mental health within the public health care system available in camps and national services is the most efficient, and cost-effective strategy. The concerned communities must be mobilized and actively involved to decrease psychiatric morbidity and increase sustainability."

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… practical tools for rapid assessment (RAMH)… 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, to summarize the challenges that lay ahead, said,

"... 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, amended and endorsed the *Tool for Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations, and Available Resources* (RAMH). They also called to integrate it in the United Nations Office for Coordination of Humanitarian Assistance (OCHA) Emergency Operations.

RAPID ASSESSMENT OF MENTAL HEALTH NEEDS OF REFUGEES, DISPLACED AND OTHER POPULATIONS AFFECTED BY CONFLICT AND POST-CONFLICT SITUATIONS AND AVAILABLE RESOURCES

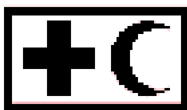
A TOOL FOR COMMUNITY-ORIENTED ASSESSMENT

VERSION FOR PILOT-TESTING

The creation of the tool became possible through the contributions of the Governments of Finland, Greece, and Cyprus

AUTHORS:
Ms Mary PETEVI, WHO
Dr Jean Pierre REVEL, IFRC
Dr Gerard A. JACOBS, DMHI

Issued by the
World Health Organization



Developed in collaboration with the
International Federation of Red Cross and Red Crescent Societies
and the Disaster Mental Health Institute, The University of South Dakota, USA

Geneva, 2001

TABLE OF CONTENTS

Chapter Page

ACKNOWLEDGEMENTS ..... **II**

INTERNATIONAL CONSULTATION "MENTAL HEALTH OF REFUGEES AND DISPLACED POPULATIONS IN CONFLICT AND POST-CONFLICT SITUATIONS" ..... **III**
PART I: GUIDELINES VII

PREAMBLE ..... **VII**
USERS OF THE RAMH AND OVERALL SCOPE: BASIC CONSIDERATIONS VIII

INTRODUCTION **1**
PURPOSE OF THE ASSESSMENT 2

RAMH TERMS OF REFERENCE (TOR) **3**
FUNDAMENTAL ISSUES 3
CHECKLIST OF BASIC RESOURCES 4
FINANCIAL/PHYSICAL RESOURCES: 4

PREPAREDNESS **4**
DATA COLLECTION TEAM 4
CARE OF THE RAMH TEAM ITSELF 5

METHODOLOGY **5**
DATA COLLECTION AND SOURCES OF INFORMATION 5
FIELD PRACTICAL GUIDELINES 7
PRECAUTIONS IN ANALYSING AND INTERPRETING DATA 8
COMMON OBSTACLES AND POSSIBLE SOURCES OF ERROR 8
ANALYSIS 10
THE RAMH REPORT 10

CONCLUSION **11**
OUTLINE OF PROJECT PROPOSAL 11
USEFUL BIBLIOGRAPHY 11

PART II: TOOL **13**

RAPID ASSESSMENT OF MENTAL HEALTH NEEDS AND AVAILABLE RESOURCES **13**
SECTION I. GENERAL INFORMATION ABOUT THE SITUATION AND THE CONFLICT 13
SECTION II. DESCRIPTION OF THE AFFECTED POPULATIONS 14
SECTION III. MENTAL HEALTH NEEDS 15
SECTION IV. CULTURAL, RELIGIOUS, POLITICAL AND SOCIO-ECONOMIC ISSUES FOR THE REFUGEES AND IDPS 16
SECTION V. BRIEF DESCRIPTION OF IMPORTANT CULTURAL ASPECTS 17
SECTION VI. MENTAL HEALTH POLICY AND RESOURCES 17
SECTION VII. CONCLUSIONS AND RECOMMENDATIONS 19

FEEDBACK FORM **23**

LIST OF PARTICIPANTS **23**

Part I: GUIDELINES

PREAMBLE

This tool is applicable to forcibly displaced populations in humanitarian crisis as a result of persecution, war, and conflict. Given the evolution of 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, 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 " include asylum seekers, refugees, internally displaced, repatriated persons, and other non-displaced populations affected by persecution, war and conflict.

"MENTAL HEALTH RESOURCES" include individual, family, community, psychological, social, and economic strengths, which can help individuals and groups of people cope with stress, trauma and suffering. This also includes human, financial, and institutional resources (including policies and action plans) which can be mobilised to support the establishment of mental health programmes.

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

The tool is also applicable in situations resulting from **GENOCIDE.**

"COMPLEX HUMANITARIAN EMERGENCY" characterises a situation of political instability leading to unrest or civil strive, internal or cross border population movements, severe economic recession, and subsequent excess morbidity and mortality. (*OCHA and Centre for Disease Control, Atlanta, USA*)

"MULTI-SECTORAL" means the collaboration in assessments, in development and implementation of responses between many professions within different ministries, NGOs, academic and research settings. These may include teachers, social workers, primary health care workers, physicians, nurses, psychologists, community health workers, counsellors, traditional healers, spiritual leaders, anthropologists, sociologists, economists, lawyers, leaders of the refugee community, associations, as well as others.

"MENTAL HEALTH PROFESSIONAL" as the term is used herein in a global context, includes a broad range of professionals with mental health knowledge and experience.

This tool is meant to be flexible, to permit its use in the above-mentioned situations, requiring an immediate qualitative assessment of mental health needs and resources. Adaptations might be needed to fit the context of future used. An effort was made to keep the language easily understood by mental health and non-mental health personnel worldwide and by those for whom English is a second language. Not all information called for in this tool will be possible to obtain in every situations. Much will depend on the timing of the Assessment. The information sought in this Tool is that considered as important in the professional literature and experience for the assessment of the mental health needs and resources in conflict and post-conflict situations.

USERS OF THE RAMH AND OVERALL SCOPE: Basic Considerations

This Tool for the Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations and Available Resources (RAMH) is intended to be used by mental health professionals, non-mental health personnel, and others involved in mental and psychosocial community support. Since in any conflict or post-conflict situation, the community and health workers are among the first level of contact with forcibly displaced people, they need a basic tool to help them assess mental health needs in emergency situations.

The information collected through use of this tool will serve to set up immediate and longer-term community-based mental health programmes. Close collaboration with mental health professionals is necessary, when they are available. This will help in project design and capacity building, which will include training, establishment of services, ongoing supervision, monitoring and evaluation, care for chronic psychiatric clients, for traumatized persons, and for psychosocial rehabilitation of the community/ties concerned.

The RAMH tool can be used immediately in emergencies; at least one mental health professional should be included in the RAMH team.

Training will be necessary for personnel with little mental health knowledge and experience. As the RAMH will be field-tested during the year 2001, a training manual will be developed and training will be provided after the tool is validated. The Feedback Form attached to the tool enables teams using the RAMH during this pilot phase to provide valuable information to WHO, to refine the RAMH and to develop the RAMH training manual.

The Comprehensive Assessment of Mental Health (CAMH) which will be developed will help provide a more detailed and comprehensive picture of the mental health needs of populations affected by conflict. Because of the urgent need for mental health response in emergencies, all efforts will be made for simultaneous progress in the three above-mentioned goals.

NOTE FOR USER:

The rapid assessment of mental health needs and resources is a process that needs careful preparation. This publication includes this preparation and the actual assessment tool.

USERS MUST READ THIS TOOL THOROUGHLY BEFORE USING IT!

INTRODUCTION

1. Conflicts and complex emergencies often result in the sudden creation of large numbers of refugees and internally displaced persons. They also subject large numbers of people who did not flee the country due to ongoing war, persecution, and violence. Conflicts involve various weaknesses in governments or even collapse of national authorities. This leads to loss of government control and can make it nearly impossible to provide vital services and protection to civilians. Conflicts result in widespread violence against people. Vulnerable groups such as the elderly, children, mentally ill and developmentally delayed, and the physically disabled pay a heavier price. Women caught in such situations become particularly vulnerable. Violence increases immediately the risk of psychological trauma within entire communities and nations. In conflicts with quickly shifting zones of combat, civilians are increasingly in the line of fire. Frequently, they become the primary targets of ethnic cleansing, murder, sexual violence, torture, and mutilation. In these situations, it is important to quickly obtain sufficient information to develop a community-based emergency mental health response, together with the affected and host communities.

2. Although the two world wars took place in the first part of the 20th century, it is in the last 50 years that more than ever people have been displaced by conflicts. The consequences of conflict on public health will have a long-term negative impact on individuals and on their communities. In the long term, it delays efforts for socio-economic development, health, reconciliation and peace. Earliest response to needs for food, water, and shelter is a mental health response. But there must also be important efforts to mobilise and provide the resources needed to respond to immediate mental health and psychosocial needs. Until now in the field of health special emphasis has been put on nutrition, prevention, on management of infectious diseases, on maternal and child health. Much less attention has been given to mental health or to psychosocial needs. However, there is a growing recognition among donors, host government, and humanitarian agencies of the importance of mental health interventions in the early phase of emergencies.

3. Another challenge is that most mental health projects have been based on psychiatric care only. It is true that within any refugee population there are chronically mentally ill and other severely traumatized because of the conflict. They must receive appropriate treatment and protection. Any traumatic event will result in distress and suffering that will have a powerful effect on individuals and communities. However, distress and suffering are not psychiatric illnesses. These reactions are normal (expected) reactions to extraordinary violent events and therefore generalized psychiatric care is inappropriate and thus must be prevented. Early and adequate mental health responses during the humanitarian emergency phase have proved to be cost effective. Such responses limit the impact of these events, and speed up coping and return to normal functioning of those affected. Any attempt to pathologize the situation must be avoided.

4. There are a few mental health interventions that are broadly acknowledged as useful to start with even before a mental health assessment is completed. These include:

- Training of humanitarian aid workers of basic mental health skills, e.g., active listening, cultural sensitivity, trauma management, community-based activities, community empowerment;
- Providing recreational, cultural space in the design of refugee camps, e.g., playground, sports field, places for religious and cultural ceremonies and other community activities;
- Establishing and maintaining a flow of reliable information and making it available to the

Communities concerned;

- Involving the concerned community/ies in decision-making processes, e.g., Where is the best location in the camp for schools, religious places, etc;
- Involving the refugee community, adults and adolescents, in concrete common interest activities, e.g., helping in camp construction and organisation, in family reunion, in food distribution, in agreed common discipline in the camp;
- Starting schooling for children, even partially;
- Support appropriate existing activities among the communities affected by conflict, within national/ camp services and informal settings;
- Organising creative and recreational activities for children as a means of strengthening the health and positive aspects of their personality as opposed to overemphasizing trauma and clinical activities (e.g., sports, theatre, singing, story-telling, dancing);
- Allowing for reestablishment of cultural and religious events;
- Facilitating creation of self-help groups;
- Facilitating inter-generational support mechanisms.

PURPOSE OF THE ASSESSMENT

1. A Rapid Assessment of Mental Health Needs, and Available Resources (RAMH) must be organised as quickly as possible during the emergency phase. The RAMH tool is applicable and can be used to evaluate needs and available resources. This RAMH should within seven to ten days collect the qualitative and basic quantitative information necessary to design and start an emergency response. It must provide reasonably accurate general information on the mental health needs and resources of the communities concerned.

2. It is important to keep in mind that the emergency RAMH should not remain the only assessment. The findings must be periodically updated. A more detailed evaluation of the needs of the vulnerable groups must follow. To this purpose, a "Comprehensive Assessment of Mental Health (CAMH: temporary name of a second tool) is under preparation by WHO.

3. On the basis of the community-oriented data collected by the RAMH an appropriate community-based emergency mental health programme can be developed. The more this programme corresponds to the needs of the people and respects their culture (religion, tradition, etc), the more effective it will be. Later on, an effective "CAMH" can provide the data necessary to refine the mental health programme and make sure that it remains both appropriate and cost effective. Periodic evaluations will indicate the progress made and will provide information to adjust to the changing needs of the populations concerned. In this document only the RAMH is developed.

4. An RAMH is required whenever a conflict or a complex emergency strikes a community. It can be requested by the government concerned, by a UN agency, an NGO, a funding source, or suggested by WHO. The purpose of the RAMH is to:

4.1 Describe the conflict[1], how it affects the area/s and the population, and identify actual and expected population movements;
4.2 Describe the affected populations[1] (estimated numbers, estimates of distribution by gender and age; estimates of numbers of orphans, unaccompanied minors, street-children, widows, raped, elderly, etc.);
4.3 Identify and rank the leading causes of mortality and morbidity among refugees[1] ;
4.4 Identify traumatic events experienced by the affected populations;
4.5 Identify the main characteristics in culture, religion, the socio-political organisation of the affected country/ies and community, and important differences with the host community;
4.6 Describe how people deal with the consequences of the violence and trauma on an individual, family, and community basis and how these coping mechanisms are affected by the current situation;
4.7 Check if a mental health policy and action plan exist and identify mental health personnel, potential paraprofessionals, and other related resources within the refugee and host communities (e.g., teachers, social workers, traditional healers, women's associations, community leaders, etc.), and external agencies;
4.8 Make recommendations for the development of a programme to respond to the needs of vulnerable groups and of the overall affected communities, taking into consideration the special needs of women and children especially for those who are alone and/or heads of household, or demobilised child soldiers.

RAMH TERMS OF REFERENCE (TOR)

1. Because of the speed with which the RAMH needs to be conducted, it is important to establish a fixed set of standard TOR for the RAMH. Careful preparation for the RAMH is very important. These broad guidelines provide the framework that will enable the RAMH team to be activated immediately and to begin the RAMH as soon as it is authorized. These TOR must be negotiated in advance, particularly if more than one agency is involved so as to prevent confusion in the field.

Fundamental Issues

1.1. Who or which agency has requested/decided to carry out the RAMH;
1.2. Who will fund the RAMH;
1.3. What are the objectives of the RAMH;
1.4. Which government sector or UN agency or NGO is taking the lead role in the RAMH?
1.5. What is the role of the Ministry of Health (MOH) or its substitute and of each agency involved?
1.6. What is the mission of the RAMH;
1.7. What are the responsibilities of each person on the RAMH team;
1.8. What are the proposed time limits for the assessment;
1.9. What are the reporting requirements;
 (a) Content should cover the eight items mentioned in paragraph 4;
 (b) Ownership of the data;

[1] Data regarding this topic may be available in other reports on the conflict collected by UNHCR, UNICEF, UNFPA, OCHA, UNDP, WHO, NGOs and by local authorities.

(c) Confidentiality of the data;
(d) Physical protection of the data in the field and after reporting;

1.10. What short and long term commitment is made by the organisations or governments participating in the RAMH to implement a mental health response.

Checklist of basic resources

2. The following human and financial/material resources can help facilitate the RAMH.

Human resources:

1. Local principal collaborator/contact person;
2. Other local professionals (multidisciplinary team);
3. Translators;
4. Drivers;

NB: At least one of the local staff and especially the driver must know the security risks and the country/area visited.

Financial/physical resources:

5. Field communications equipment (especially for security reasons);
6. International and field transport;
7. Portable computers and related supplies.

PREPAREDNESS

Data Collection Team

Selection and training of RAMH Team

1. Because of the urgency of the RAMH, it is recommended that a pool consisting of both local and international professionals be identified in advance. These prospective members can then be trained in the RAMH methodology. It is best for the RAMH team to be multidisciplinary, but of special importance is knowledge and experience in refugee mental health and in emergencies. Personal characteristics are very important, particularly the capacity for teamwork, for work under pressure and for mutual support. Because conflict can have unpredicted consequences and because experienced professionals are not always readily available, it is important to train a sufficiently large pool of team members, to ensure that adequate numbers are available at the time of an emergency. In each team at least one must be a professional experienced in working in crisis situations.

2. The RAMH team needs to have basic information concerning the population, culture, religion(s), language, context of the conflict, conditions of flight, etc. before starting the assessment. This information can be prepared in advance for areas of the world where conflict is anticipated, and updated periodically.

3. The RAMH must be undertaken during the emergency phase as soon as basic survival needs are met. Based on the characteristics of the conflict and the availability of team members, adequate persons from the pool can be selected and mobilized. One member of the team must be identified as the team leader and another as the secretary. Responsibility for other specific duties

can be given to team members according to the TOR of the RAMH and to the situation. This provides an effective division of labour, as well as attention to each aspect of the RAMH. The size and possibly the composition of the team are likely to change as the RAMH moves toward the CAMH.

Care of the RAMH Team Itself

4. Care of the RAMH team needs to be a serious concern throughout the RAMH. Team members can be exposed to accumulation of traumatic scenes, stories, difficult living and working conditions, and to bureaucratic challenges, to lack of security and to danger. Minimum periods should be reserved on a daily basis for rest, short regular recuperation periods for team-support sessions.

5. Before sending the team to the field, information is needed related to the team's safety. This pre-deployment information can be obtained from government, UN agencies, national and international NGOs. Basic information needed:

- 5.1. Security of the urban and rural areas, areas of military operations or other threatening situations;
- 5.2. Security requirements and assets (regulations, clearances, laissez-passers for camps, safety jackets, helmets, etc.);
- 5.3. State of roads, bridges, airports, availability of transport, communications, etc.;
- 5.4. Access to the territory (road convoys, river and sea shipping, airlifts and airdrops, "humanitarian corridors", "windows of peace", etc.);
- 5.1. Prevalence of endemic diseases, vectors, vaccines needed, etc.;
- 5.2. Availability of medical treatment and evacuation plans/regulations;
- 5.3. Presence of unexploded landmines, bombs, and artillery shells;
- 5.4. Communication network;
- 5.5. Procedures for international aid agreements;
- 5.6. Rights and authorizations for movements of people and goods (international flights, transit, landing);
- 5.7. Visa, customs regulations, clearance, number of photos needed, etc.;

6. At the end of the RAMH a meeting of the team should be organised to process together their experience.

METHODOLOGY

1. The RAMH depends not only on the discussions with and reports by governments, agencies, and others familiar with the situation. The RAMH team must visit and directly observe the refugee/displaced camps, and sites hosting other populations affected by conflict, including those most impacted, even in very remote areas. It is very important to include members of the affected communities in the assessment process. In a situation with important political, security, military, ethnic, and other problems, there is a risk that the data collected are unduly influenced by the opinions or by the biases of those consulted, or by written reports. Therefore, the RAMH team must remain independent, vigilant, and neutral in order to limit systematic biases.

Data Collection and Sources of Information

2. Work in the early days of emergencies is chaotic, and data collection during a RAMH may not advance in a step-by-step, logical fashion. Nevertheless, a good plan for collection

and analysis will lead to a more reliable report. Enough time must be given at the beginning to identify the most adequate and relevant individuals to interview.

3. The RAMH uses a multifaceted approach, gathering information from key sources representing agencies of the affected government(s), UN Agencies, NGOs, local academics, researchers, and members of the affected and host communities. The assessment must cover all levels. Data collection must include central and peripheral levels – rural and urban – from national, and international sources. Populations in/from highly impacted areas should be given priority. Information can be collected from existing documents, interviews, and visits to the affected areas. Information collected from news media is important, however media information may be biased and needs to be cross-checked.

4. It must be understood that any rapid assessment is a compromise between available resources, constraints and needs. Therefore, the margin of error inherent in the data collection must be kept as low as possible. Sensible, suspicious or inaccurate information must be cross-checked. For a number of reasons, is not always possible to consult with all the possible sources of information listed below. The higher the number of sources consulted, however, the better the quality and objectivity of the data collected. Therefore, critical thinking will be needed in order to select and access the most relevant sources of information.

Central and regional national authorities:

4.1 Ministry of Health;
4.2 Ministry of Education;
4.3 Ministry of Social Welfare or of ad hoc Ministries (For example, "interior" and "security", "reconstruction", or "rehabilitation";
4.4 Other ad hoc central district offices, local refugee offices, local UN administration, etc.;
4.5 Other national, regional, and local administrative authorities;
4.6 Regional/local security authorities;
4.7 Refugee community;
4.8 Non-state entities.

Representatives of agencies, associations, services, universities:

4.9 Central UN administration in-country, if any;
4.10 UN agencies;
4.11 NGOs – international, regional and local;
4.12 Religious groups, spiritual community and religious leaders;
4.13 Indigenous/traditional healers;
4.14 Cultural anthropologists, sociologists if any;
4.15 Health and mental health professionals and relevant associations if any;
4.16 Women's, youth, disabled, minority groups or associations.

Intersectoral sources:

(Note that information will be sought from and shared with other assessment teams).

4.17 Physical health;
4.18 Specialized mental health services;
4.19 Rehabilitation centers for physically disabled;
4.20 Pre-existing social welfare and services and newly introduced activities for:
   (a) Families: including family reunification, refugees, displaced, returnees, etc.;

(b) Women: widows, survivors of torture/ rape, kidnapping, etc.;
(c) Children and adolescents: including unaccompanied minors, orphans, street children, children/adolescent head of families, and child soldiers;
(d) Survivors of extreme violence (rape, torture, abducted) and former detainees/prisoners during conflicts and their families, including released prisoners of war;

4.21 Other vital sectors: food, water, shelter, sanitation;
4.22 Education: primary and secondary school teachers, professors at universities, post secondary technical/vocational schools;
4.23 Cultural, youth, sports, and social groups: clan, village, camp, and community leaders, representatives of the elderly;
4.24 Police, army, and other local or international security forces.

Cautionary notes about data collection

5. During visits to the affected areas, even careful observation may result in a biased impression. The area visited may be more or less severely affected than the rest. Therefore, quick generalizations must be avoided. In addition, the most severely affected persons are often the least visible; those injured or sick and those who have been most traumatized, avoid contact and are less accessible to visitors. Personal impressions and notes are useful, but these must be kept separate from the factual observations and data.

Field practical guidelines

6. WHO or the agency responsible for the RAMH should make the initial contacts and preparations. This is best done with local counterparts.

7. In the field, the RAMH team needs to introduce themselves and outline quickly the terms of reference and the method of the assessment. Avoid unnecessary jargon or acronyms. Be careful not to raise hopes too high. Treat everyone with respect. The best way to avoid being seen as a tourist, donor, or voyeur is to treat those met as valued colleagues. Explain what will be done with the information gathered. Avoid to take originals of documents from the site, make copies.

8. Remember that staff working in emergencies has heavy workloads and difficult living conditions. They will stay behind; therefore, it is of utmost importance not to overload or expose them, their families or colleagues to additional security risks. It is important to carefully prepare questions to be asked, so that they can be presented in a non-threatening way. The RAMH team needs to openly express their appreciation for the good being done by existing initiatives (local and international).

9. The RAMH team must adopt ethical behaviour and good citizenship. Working lunches/dinners are often necessary. But remember that meals, transport, and other expenses should not be imposed on field workers. Do not impose late evening meetings away from the residence of people, particularly if there are security problems. Remain alert to the security risks of travelling too early in the morning or late in the evening both for the RAMH team and for the community members with whom the team is meeting.

10. Special attention is called to the fact that emergencies remain politically sensitive situations in which security is frequently a problem. The RAMH team must be sensitive to the consequences of their selection of people and organisations with whom they will be working. In addition, one should

not underestimate the influence of the financial and material benefits provided to local staff during the field mission. Such elements can become a source of unnecessary pressure, which will eventually affect the quality of the information collected.

Coordination with additional organisations

11. Numerous organisations are likely to be in the field responding to the emergency. The RAMH team must contact the most relevant to gain their collaboration and support and avoid duplication. Co-ordination and sharing of resources will produce a more complete and accurate assessment and save funds for direct services delivery.

12. It is important to ensure that RAMH staff includes local community members in most phases of the RAMH assessment. Likewise, international NGO staff with the required knowledge of the situation can be called upon. This contributes to capacity building at each level of participation, and is likely to add to the validity of the data and improve future interventions and collaborations.

Precautions in analysing and interpreting data

13. It is important to remember that information obtained from interviews is often biased by the interviewees' personal history, emotional condition, and intellectual capacity at that moment. There are objective and subjective biases. The way a person reports on actual events may be more or less accurate, introducing an objective bias. Objective biases may also result when individuals provide "official" information that may be deliberately inaccurate. It is difficult to distinguish fact from rumour, while in the chaos of a conflict official information can be tainted by inaccuracy almost as often as local gossip.

14. Subjective biases result when individuals allow personal, cultural, ethnic stereotypes, or prejudices and expectations to affect their judgement. They also occur when individuals intentionally exaggerate the extent of damage or trauma to obtain emergency assistance for those they represent, or to protect the image of the agency or government they represent. These biases can be aggravated by those of the RAMH team.

15. In emergencies, “hard data” are almost impossible to obtain. The lack or poor quality of information is in itself information. But comparing data and viewpoints from different sources can help to build a more accurate picture of the situation. Unofficial sources may be able to tell whether lack of data lies in the chaos of the situation, or the lack of support for mental health aspects among government or agencies, or other causes or a combination of the two.

16. Difficulty in accessing certain areas may be the greatest constraint. Defining on the map the accessible areas, the "grey zones" about which little is known, and the "black holes" about which nothing is known will help to determine how much the situation is actually reflected by the collected data, and thus will indicate the quality of the assessment.

Common obstacles and possible sources of error

17. Common sources of error may be logistical, organisational, or technical. The most frequent sources of error are listed below.

Logistical – Inadequate Resources:

17.1. Transport and fuel problems;

17.2. Communications problems (at various levels);
17.3. Accommodation problems.

Solution: Develop as early as possible a checklist of needed provisions and resources, and adjust with flexibility according to availability in the field.

Organisational/Institutional:

17.4. The responsibilities of each team member are not well defined;
17.5. The team members have never met before;
17.6. Authorities, key decision makers, and possible donors in charge of the area(s) targeted for assessment are not informed and are not ready to assist or meet the RAMH team;
17.7. Key decision-makers and possible donors may also be under pressure to respond to political demands even before the findings and recommendations of the assessment are known, resulting in inappropriate assistance;
17.8. The assessment is conducted too late, or it takes too long, or it does not provide sufficient information;
17.9. Irrelevant information is collected.

Solution: Better preparation before leaving and better organisation in the field. Early contact and involvement of all relevant stakeholders (or agencies).

Technical:

17.10. Skilled and experienced professionals are not involved in the assessment;
17.11. Assessment conclusions are based on data that do not represent the true needs of the affected population;
17.12. Information received from field workers and official interviews is taken at face value, without cross-checking all sources.

Solution: Careful and continued monitoring of mission process and data collected.

Remember that situations may change quickly. Collect the most recent data and continue monitoring the situation when drafting the report. Depending on the situation, circulate and discuss preliminary conclusions while processing the final report.

Precautions for the RAMH in repatriation operations

18. It is important to remember that the end of a conflict may increase distress for a certain time, due to the following:

18.1. News of deaths of family members, relatives, or friends may be learned during this phase;
18.2. Families returning to their homes may find that their home and/or other property has been looted or destroyed, or occupied by others;
18.3. There may be a return of demobilized soldiers, which can greatly increase tensions in the community, in particular if they their weapons.

Analysis

19. During conflicts, the situation can change very rapidly. The analysis of data must be collected quickly and thoroughly, and the results made urgently available to decision-makers to draw the greatest benefit from the assessment. It is best for the analysis to use standardized categories of information as described in this tool. The analysis must be as specific as possible to ensure the best development of community-based, phase-specific programmes.

The RAMH Report

20. The RAMH Report needs to be standardized in the same manner as the data analysis. It will consist of the same "chapters" as for the objectives. In addition, there will be at least four annexes to it:

- 20.1. **National mental health policy and other relevant documents, if any;**
- 20.2. **Other situational, health, or mental health reports, if any;**
- 20.3. **The List the active local and international relief agencies and the key persons;**
- 20.4. **The List of (with names of contact persons) local and international agencies involved in psychosocial projects; copies of such projects should be collected.**

21. The report needs to be clearly worded. Decision-makers or staff of local, national and international organisations whose actions depend on the results of the RAMH may have little training in interpreting mental health data. Avoid technical jargon to permit rapid reading and decision-making, avoid presenting a voluminous report. Depending on situations, producing a detailed report before departure from a country might not be advisable. The complexity of the situation might require a few days of reflection to prevent hasty conclusions and decisions that might lead to damaging actions. It is therefore preferable to deliver preliminary conclusions and recommendations for immediate actions while waiting for the detailed report to be issued.

22. In the report, give clear indication of the immediate priority needs and how to address them with community-oriented phase-specific programmes. The needs of the chronic mentally ill are to be distinguished from those resulting from the conflict. Make clear recommendations regarding the best approaches, strategies, and programmes. If possible, try to provide the worst and best-case scenarios and a contingency plan for the next 3-6 months, what will be the mental health priorities if the conflict continues or if a peace is reached.

Responsibility for the Distribution of the Report

23. Distribution of the Report is the responsibility of the organisation or government that has undertaken it (see Terms of Reference, page 3).

CONCLUSION

In conclusion, the RAMH is an important tool for the immediate assessment of mental health needs and resources in conflict and post-conflict situations. This tool can be used in both the emergency phase and in ongoing unstable post-conflict situations. The RAMH report will include recommendations for the development of a community-based, phase-specific, mental health programme. It will also describe available individual, family, and community strengths and human, financial, and material resources, including political support. It will provide useful cultural/ religious/ ethnic elements to be considered for both the refugee and other populations affected by conflict and host community/ies. Recommendations made in the report must aim at bridging emergency to longer-term actions and development. Finally, it is important to note that the RAMH is a first step to be followed by a more comprehensive assessment, when the CAMH tool is available.

The RAMH report will not contain a mental health project proposal but it will serve as a basis for its construction. The following project outline, being used by WHO and others, could be useful.

Outline of Project proposal

1. Background information on the conflict, on the forcibly displaced populations concerned and on the host community, environment, etc.;
2. Proposed project: outline overall perspective of location and duration of the project;
3. Objectives;
4. Activities, duration, collaborations;
5. Monitoring methods;
6. Qualitative evaluation (if possible also quantitative);
7. Reporting modalities;
8. Estimated budget.

Useful Bibliography

Ref: "Declaration of Cooperation: Mental Health of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations", World Health Organization, 2000;
Ref: WHO/UNHCR "Mental Health of Refugees", WHO, 1996;
Ref: Dr G. H. Brundtland, Director-General, World Health Organization, Editorial "Mental Health of Refugees, Internally Displaced Persons and Other Populations Affected by Conflict" in Acta Psychiatrica Scandinavica, 2000, Munksgaard, Copenhagen;
Ref: Petevi, M. "Forced Displacement: Refugee Trauma, Protection and Assistance. In Y. Danieli, N. Rodney and L. Weisaeth, (Eds) in International Responses to Traumatic Stress. New York: United Nations Publications, Baywood Publishing Co.

Part II: TOOL

RAPID ASSESSMENT OF MENTAL HEALTH NEEDS AND AVAILABLE RESOURCES

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
The data indicated below are needed for an effective assessment. The checklist is put in tables to help the RAMH team to keep track of the collection process. The answers should not be recorded on this form. These tables are to be used by the RAMH team leader or secretary to maintain an overall picture of which information was obtained by team members or by different teams. The section headings can serve as an outline for the RAMH report. Numbers/ estimates and other similar information must be described and reported with great caution to avoid over interpretations and misunderstandings.				
SECTION I. GENERAL INFORMATION ABOUT THE SITUATION AND THE CONFLICT **Description of the conflict, of the affected areas, of the populations and expected movements**				
1. Geographic and environmental (natural) characteristics of the affected area				
2. Previous conditions in the affected area; what was life like before the conflict; changes occurred due to the conflict				
3. Administrative and political divisions in the affected area				
4. Nature of the conflict itself				
5. Expected developments of the conflict				
6. Expected population movements - population movements that have already taken place				
7. Adequacy of security, types and degree of violence: Attacks, invasions into refugee camps, killings in affected areas, abductions, looting				
8. Basic survival situation and needs:				
(a) Morbidity, death rates, and causes (age, gender specific if possible)				
(b) Food supplies, recent food distribution, and future food needs				
(c) Supply and quality of water				
(d) Adequacy of sanitation				
(e) Other basic survival priority needs of the affected population				
(f) Situation of shelter and clothing				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
9. Economic aspects: employment or income generation activities, unequal distribution of resources and positions by ethnic, political, or other kind of grouping				
10. Community aspects: solidarity, ongoing political, ethnic, other tensions, problems with youngsters, other groups				
11. Education				
(a) Current education programs for the refugee / displaced community/war-affected community				
(b) Important problems for education generated by the conflict				
(c) Current roles and activities of teachers (if not employed in formal education)				
(d) Status of transport, fuel, communication, and other logistic necessities				
SECTION II. DESCRIPTION OF THE AFFECTED POPULATIONS **Statistics are not always available during a crisis. Therefore data collected on these aspects can be simple estimates.** *Remember the different categories of affected populations and the variability within each of them: refugees, internally displaced, existence of old refugee groups/displaced populations, if the problem is not new, returnees, non-displaced war-affected populations, others.*				
1. Estimates on population by age, gender, and vulnerability				
2. Orphans, unaccompanied minors, street children				
3. Children / adolescent heads of household				
4. Demobilized child soldiers, ex-soldiers, active soldiers, ex-"freedom fighters"				
5. Single mothers				
6. Survivors of torture, sexual violence				
7. Widows				
8. Elderly				
9. Chronically mentally ill: in institutions, in families, or elsewhere				
10. Physically disabled and developmentally delayed				
11. Average household size				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
12. Ethnic composition and place of origin of affected population (Where are they from?)				
13. Location of the affected population: type: camps, transit centers, besieged villages, towns; environment: rural, urban, desert, jungle, tropical; accessibility: easy, difficult, dangerous, etc.				
14. Mapping of the locations and estimated numbers of various types of the affected populations				
15. Location and number of those living with relatives, and local people in rural and urban areas				
SECTION III. MENTAL HEALTH NEEDS **Exposure of the population affected by the conflict to violence and to traumatic events and current camp life**				
1. How sudden was the move?				
2. When and how refugees arrive in present locations? What have they gone through?				
3. Killings, executions, missing				
4. Ongoing /daily violence harassment: against whole populations or against women, or other groups				
5. Torture				
6. Sexual violence against adults or children				
7. Domestic violence, including child abuse				
8. Armed attacks, artillery shelling, bombing, etc.				
9. Separation of family				
10. Forced to perpetrate violence against their own family, community, nation				
11. Type of disruption of most important cultural and social rituals, family and community structure				
12. Abduction				
13. Imprisonment, detention in re-education/ concentration camps and other kind of settings				
14. Deprivation of food/water				
15. Epidemics with deaths				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
16. Breakdown of traditional family roles and support networks				
17. Ethnic, political, religious disputes				
18. Lack of privacy				
19. Disruption of status (e.g., economic decline, loss of power in the community)				
20. Extortion				
SECTION IV. CULTURAL, RELIGIOUS, POLITICAL AND SOCIO-ECONOMIC ISSUES FOR THE REFUGEES AND IDPs				
1. Community characteristics before and after the conflict - strengths - resistance				
2. Social structure; clans, tribe, ethnic				
3. Are there any psychological support structure and type of administration: civil, military (example: family, church, community)?				
4. Family structure: extended family, handling of financial resources, of family problems/hazards				
5. Economic structure: kind of production and management of resources at family, district/or camp and national levels				
6. Brief history of the host community or country, including conflict and disaster history				
7. Brief history of the relationship between host, refugee and displaced groups				
8. Sanctions/taboos about specific topics, traditions, rituals or social interactions: ex deaths, burial, mourning, rape, acts of revenge, justice, etc.				
9. Religious and spiritual aspects of host nation: ex. Are they similar to those of refugee community, are the relationships friendly in spirit of solidarity or very different creating or maintaining tensions and problems				
10. Emerging social structure and self-organization in the concerned community, existing activities				
11. Are there any emerging community leaders and what kind – political, ethnic, religious, ex-military, ex-freedom fighters?				
12. What kind of emerging social groups or associations, parties, etc. are there?				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
SECTION V. BRIEF DESCRIPTION OF IMPORTANT CULTURAL ASPECTS Describe how people deal with consequences of violence and trauma: individual/family/community levels and how these mechanisms are affected by the current situation				
1. Is the society matrilineal or patrilineal?				
2. Kind of religion/s and role of priests, traditional healers, kings, other community "authorities"				
3. How did/does the community treat and consider people with physical illness and handicaps?				
4. Ways conflict and disagreement are dealt with by people in the current situation				
5. How are emotions/thoughts expressed? (For example, sadness, anger, happiness, suspicion, fear, attitudes, disagreement, intolerance, prejudice, etc.)				
6. How did the culture/traditions of the refugee community consider and react to mental illness and problems? Has this changed as a result of the conflict?				
7. Do people ask for help or for psychological support when they need it? If yes, how are they seen by their community?				
8. How do people understand and deal with violence and suffering?				
9. How do people deal with death, burial, bereavement and loss?				
10. In the current context, are there any situations in which traditions and rituals can not be practised? (For example: for the missing, for the children born as a result of rape, for those who are buried on the way to exile, or when hiding in remote areas, in exile, or in the camps, etc.)				
SECTION VI. MENTAL HEALTH POLICY AND RESOURCES **General information on mental health policy and action plan**				
1. Is there a national mental health policy on prevention, emergency response relief, and longer-term programs? Does it apply to asylum seekers, refugees, displaced, and other non-displaced populations affected by the conflict?				
2. If this policy existed before the conflict, has it been adapted to the current needs?				
3. Does a mental health operation plan exist? Is it being implemented? If so, by whom, where, since when? How can a copy of the plan be obtained? How does one contact the people in charge?				
4. Is there a person in the MOH or in the designated body responsible for mental health activities?				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
Mental health resources available in the affected and host communities				
5. Is there a data collection, dissemination, and updating system including follow up on the security, human rights violations, and other problems with an impact on mental health? Which organization is responsible for it?				
6. Were any other mental health needs assessments carried out? By whom? For what purpose? Were locals or refugees involved? Were the organisers/authors be contacted? How can the reports be obtained?				
7. Are there national mental health strategies addressing the emergency?				
8. Is there any national mental health personnel in the area of concern? If yes, what type and how many?				
9. Are there any mental health professionals within the refugee community, within the camps? What type and how many?				
10. How can these people be reached?				
11. What mental health training activities are available? By whom?				
12. What are the salaries of national health personnel? If a national scale does not exist, obtain minimum payment requirements, because it will be needed in the budgeting of the project which will result from the recommendations.				
13. What is the percentage of budget and the actual amount of money allocated to mental health by UN agencies, NGOs, government, others?				
14. Are there any international projects available to respond to mental health needs? If yes, obtain copies of projects and other relevant info.				
Resources, coping skills and behaviour strengthening at personal and community levels of reconstruction and functioning				
15. General resiliency and functioning of the community				
16. Does community show cohesion and solidarity?				
17. Is there communication between tribes, ethnic/political groups, the refugee, and host community (ies)?				
18. Do formal or informal educational activities, including extracurricular ones exist?				
19. Is there any support or self-help groups within the refugee community and or host support groups? (For example, between children, adolescents, adults, elderly, or between women and men, among the disabled, among women?)				

Data to be collected	REFUGEES YES	REFUGEES NO	HOST POPUL. YES	HOST POPUL. NO
SECTION VII. CONCLUSIONS AND RECOMMENDATIONS **Recommendations for an immediate and long term community-oriented mental health response based on the findings of the RAMH; the report should include most important facts among which the following**				
1. Recommendations for immediate and long-term care of the most vulnerable				
2. Recommendations for immediate and longer term care of the most serious mental health problems of the overall population. What inter-generational activities, exchanges, support exists and what is needed?				
3. Recommendations for immediate and longer term capacity building				
4. Recommendations of immediate and longer term implementation of mental health programme				
5. Indication of available resources/ indication of required resources				
6. Provide from list of agencies involved (to be annexed) indication of possible collaborations				
7. Describe major obstacles – constraints, risks, assets for implementation of a mental health programme				
8. Recommendations in priority of the most cost-effective local interventions, external support and collaborations needed				
9. Existing activities and location (city contacts) of self-organization of the community must to be maintained or expanded as a significant power resource of the community				
10. Existing activities organized by the host community and local and international agencies to be maintained or expanded				
11. Ways to prevent breakdown of national services and local NGOs by excessive recruitment of local and regional staff or by introduction of wage discrepancies in salary scales by international agencies.				

End of the Tool

FEEDBACK FORM

for the TOOL
Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations in Conflict and Post-Conflict Situations, and Available Resources
WORLD HEALTH ORGANIZATION, Geneva, 2001

After using the RAMH, please provide the following feedback to assist in revising the Tool to make it as useful as possible for the user in the field. Please print or write clearly so that your comments can be used. Please use the back of this sheet or attach additional pages if necessary. Thanks for sending it to:

Ms Mary Petevi
Emergency Health Intelligence and Capacity Building
Department of Emergency and Humanitarian Action (EHA)
World Health Organization (WHO)
20, Avenue Appia
Geneva 27, SWITZERLAND
Tel: 41 22 7914232, Fax: 41 22 7914844, E-mail: petevim@who.ch

In which situation and country/ies did you use this tool?

Questions to be added:

Material to be deleted:

How can the format of the RAMH be changed to be more effective?

What worked best about this tool?

What was most cumbersome about the tool?

What other suggestions do you have?

LIST OF PARTICIPANTS

INTERNATIONAL CONSULTATION MENTAL HEALTH OF REFUGEES AND DISPLACED POPULATIONS IN CONFLICT AND POST-CONFLICT SITUATIONS FROM CRISIS THROUGH RECONSTRUCTION

Geneva, 23-25 October 2000

Opening session

Chairperson: Dr David NABARRO
Executive Director, Director-General's Office, World Health Organization

SPEAKERS:

Dr Gro Harlem BRUNDTLAND
Director-General
World Health Organization

Ms Mary ROBINSON
High Commissioner
Office of the United Nations High Commissioner for Human Rights

Mr Frederick BARTON
The Deputy High Commissioner
Office of the United Nations High Commissioner for Refugees

Mr Pekka HUHTANIEMI
Ambassador
Permanent Mission of Finland to the United Nations Office at Geneva

Mr Hakan SANDBLADH
Deputy Director, Department of Health
International Federation of Red Cross and Red Crescent Societies (IFRC)

Ms Erin MOONEY
Special Representative, Dr Francis Deng's Office
UN Secretary-General's Office on Internally Displaced Persons

Dr Xavier LEUS
Director, Emergency Humanitarian Action
World Health Organization

Dr Benedetto SARACENO
Director, Department of Mental Health and Substance Dependence
World Health Organization

Dr Joop de JONG
Director
Transcultural Psychosocial Organization

Ms Mary PETEVI
Department of Mental Health and Substance Dependence
World Health Organization

PARTICIPANTS:

1. Dr Ferid AGANI
WHO Mental Health Assistant
Department of Neuropsychiatry
University Clinical Center
38000 Pristina, KOSOVO

2. Mrs Uju AGOMOH
Executive Director
Prisoners Rehabilitation and Welfare Action (PRAWA)
1A Bode Thomas Street
P.O. Box 2061, Sabo-Yaba, Lagos
NIGERIA

3. Dr Florence BAINGANA
Mental Health Specialist, Health Nutrition and
PopulationThe World Bank
1818 H Street NW, D.C. 20433
Washington, USA

4. Dr Ahmad BAKER
Professor of Psychology, Birzeit University
Jerusalem, PALESTINIAN TERRITORIES

5. Prof Constantinos BALLAS
Ministry of Health/KEEL
GREECE

6. Dr Helen BAMBER
Director, Medical Foundation for Torture Care
(Former Secr., Int Assoc. for Health and Human Rights)
96 Grafton Rd
NW5 3EJ London, UNITED KINGDOM

7. Dr Thierry BAUBET
Psychiatrist, Medecins Sans Frontieres
8 St Sabin 75011
Paris, FRANCE

8. Ms Lena BREMER
Director, Crisis Prevention Center
the Finnish Association for Mental Health
Simonkatu 12 B 13
FIN-00100 Helsinki, FINLAND

9. Dr Mustapha ELMASRI
Consultant Psychiatrist
Societe Algerienne pour Recherche en Psychologie
Villa No33 El Omrania
Dely Ibrahim
Alger, ALGERIA

10. Dr Suman FERNANDO
Professor, University of Kent and North London
Member of Mental Health Act Commission (UK)
20 Burghley Road, Kentish Town, NW5 1UE
London, UNITED KINGDOM

11. Dr Edvard HAUFF
Consultant Psychiatrist
Department of Psychiatric Research and Education
Ullevaal University Hospital
0407 Oslo, NORWAY

12. Dr Gerard A. JACOBS
Director, Disaster Mental Health Institute
University of South Dakota - SDU114
414 East Clark Street
Vermillon, SD 57069-2390, USA

13. Mr Ranjith JAYASINGHE
Chief Occupational Therapist, Mental Hospital
454/1A Dutugemunu Road
Colombo, SRI LANKA

14. Dr Joop de JONG
Director, Transcultural Psychosocial Organization (TPO)
Keizersgracht 329
1016 EE Amsterdam, The NETHERLANDS

15. Mr Noureddine KHALED
President, Societe Algerienne de Recherche en
Psychologie (SARP)
Villa No 33, El Omrania, Dely Ibrahim
16320 Alger, ALGERIA

16. Dr Anica Mikus KOS
Slovene Philanthropy
(Association for Promotion of Voluntary Work)
1000 Ljubljana, SLOVENIA

17. Ms Guiseppine LABELLARTE
Italian Psychiatric Organization
Stradella Carducci 5, 70124
Bari, ITALY

18. Dr Pirkko LAHTI
President , World Federation for Mental Health
Maistraatinportti 4A
FIN-00240 Helsinki, FINLAND

19. Dr Jean Claude METRAUX
Director, Appartenances (NGO)
Rue des Terraux 10, Lausanne 9, SWITZERLAND

20. Dr Richard MOLLICA

Director, Harvard Program in Refugee Trauma
8 Story Street, 3 floor, MA 02138
Cambridge, Massachusettts 02138, USA

21. Dr Edward NAHIM
National Coordinator for Mental Health, Ministry of Health
34 Ecowas Street
Freetown, SIERRA LEONE

22. Dr Flavio del PONTE
Senior Medical Advisor, Swiss Disaster Relief Unit
Federal Department of Foreign Affairs
Eigerstrasse 71, CH-3003 Bern
SWITZERLAND

23. Mr Francisco QUESNEY
Project Officer, Child Protection
United Nations Children's Fund
New York 10017, USA

24. Dr Jean-Pierre REVEL
Head of Project, International Committee of Red Cross
19, avenue de la Paix
Geneva, SWITZERLAND

25. Dr Bhogendra SHARMA
Medical Director CVICT
P.O. Box 5839, Bansbari-3
Kathmandu, NEPAL

26. Ms Beatrice STAMBUL
Psychiatrist, Medecins du Monde
19 Boulevard Chave
13005 Marseille, FRANCE

27. Dr Nora SVEAASS
Secretary General
International Society for Health and Human Rights
Urtegt. 50, 0187 Oslo
NORWAY

28. Dr Loes van WILLIGEN
Former Medical Director Pharos and
Honorary President of ISHHR
Foundation for Refugee Mental Health Care
Prinseneiland 11-II
1013 LL Amsterdam
The NETHERLANDS

OBSERVERS (Permanent Missions):

Australia, Belgium, Canada, Cyprus, Finland, France, Germany, Greece, Ireland, Italy, Japan, Netherlands, Norway, Sweden, Switzerland, United Kingdom, United States of America.

OBSERVERS (Representatives of United Nations agencies, international organisations and NGOs):

United Nations Development Programme (UNDP)
United Nations High Commissioner for Refugees
United Nations High Commissioner for Human Rights
United Nations Children's Fund (UNICEF)
United Nations Population Fund (UNFPA)
Office for Coordination of Humanitarian Assistance
International Committee of Red Cross (ICRC)
International Federation of Red Cross (IFRC)
International Save the Children Alliance (ISCA)
International Organization for Migration (IOM)
International Catholic Child Bureau (ICCB)
International Rescue Committee
International Council of Voluntary Agencies (ICVA)
World Council of Churches (WCC)
World Federation of Mental Health, Swiss Representation
World Psychiatric Association (WPA)
CARE International, Geneva
Center for Rehabilitation of Torture Victims, Greece
Red Cross Center for Rehab. of Torture Victims, Bern
Ms Liliana Urbina, WHO, Kosovo
Mr Franz Baro, Psychosoc & Psychol. Factors, Belgium

The WHO REPRESENTATIVES of various departments from Headquarters.

SECRETARIAT of the Consultation:

Dr Benedetto Saraceno, Director, Department of Mental Health and Substance Dependence (MSD)
Dr Shekhar Saxena, Coordinator, MSD
Ms Meena Cabral de Mello, MSD
Ms Mary Petevi, MSD
Dr C. Mandlhate, WHO Regional Mental Health Adviser, AFRO
Ms Elmira Adenova, MSD
Ms Mylène Schreiber, MSD
Ms Roshni Fernando, MSD

Contact: Ms Mary Petevi
Technical Officer
Department of Emergency and Humanitarian Action
Cluster of Sustainable Development
World Health Organization

Address: 20, avenue Appia
1211 Geneva 27
Switzerland

Tel: 41 22 7914232/ 7914939
Fax: 41 22 7914844
E-mail: petevim@who.ch