GLOBAL HEALTH RESEARCH INITIATIVE
TEASDALE-CORTI TEAM GRANT PROGRAM

TRAUMA & GLOBAL HEALTH PROGRAM

MID-TERM EVALUATION REPORT

Title: Political violence, natural disasters and mental health outcomes: developing innovative health policies and interventions

IDRC Grant Number: 103460-039

Name of leading research institution: Douglas Mental Health University Institute – Research Centre - McGill University

Partner countries: Guatemala, Nepal, Peru, Sri Lanka and Canada.

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ANNEXES NEPAL:

ANNEXES SRI LANKA:

Mid Term Evaluation Framework

Vision

The Trauma and Global Health Program (TGH) is based on partnerships between the Douglas Institute - McGill University and research teams based in Guatemala City (Guatemala), Kathmandu (Nepal), Lima (Peru), and Colombo (Sri Lanka). Its ultimate objectives are: to reduce the mental health burden of civilian populations exposed to protracted and endemic political violence and/or episodic natural disasters; to foster the process of healing, psychosocial rehabilitation and recovery; and to generate improved mental health policies and services in the participating countries. Thereby it will contribute to reassessing humanitarian responses and strategies for healing and coping by moving beyond the narrow psychological focus toward a wider perspective of the social and cultural context in which people live, cope with and recover from potentially traumatic experiences. The TGH three main spheres of action are research and documentation (R&D); capacity building (CB); and knowledge transfer (KT).

Mission statement

In support of the vision, the Canadian-based team works in partnership with three NGOs: PRDA in Sri Lanka, CVICT in Nepal, and CBIP in Guatemala; and a private university (UPCH) in Peru. To facilitate cross-national comparison, research and documentation (R&D) focuses on three basic sets of questions: 1) local variations in the expression of distress and perceived effects of trauma exposure, and their cultural and gender variations; 2) cultural adaptation of assessment tools, models of clinical practice, and collective interventions; 3) potential trade-offs between individual and community level interventions.

The TGH Program is actively involved in capacity building (CB) in multiple ways. Team members from all participant country sites and McGill are continually working towards strengthening the program network's capacity through regular video-conferences and email exchanges, country site visits and the annual meeting. Through this dynamic web of experts, the program is also working on a Trauma & Global Health webpage and newsletter, and on-line course that will be offered in 2009-2010. To build capacity for LMIC scholars and fellows the TGH Program offers an annual winter course, summer student's fellowships, in-service research and trainings scholarships, and mentoring staff and students in research work and scientific writings.

To reach the various stakeholders and research end-users the THG Program uses different knowledge transfer (KT) strategies. Its emphasis is on a participatory action approach that will allow us to work effectively in challenging environments such as post-conflict/disaster operations and resource-poor settings. Thus, the program aims at the following groups of actors: 1) the lay-community domain includes a variety of stakeholders, the communities which have been affected by violence or disaster induced

trauma, including post-trauma survivors and their families; 2) the health care domain includes academics (LMIC Co-PIs, researchers, key members, and consultants who are part of the TGH team), and the wider network of health care providers, including primary health care workers, and 3) the institutional and humanitarian aid domain including government officials, NGOs, humanitarian aid organizations' staff, program managers and policymakers.

Introduction to the MTE framework

In consultation with main stakeholders the TGH Program decided to conduct the midterm evaluation using 'Outcome Mapping' as a frame of reference (Annex 1). Outcome Mapping (OM) focuses on specific types of results or effects mostly defined in terms of behavioural changes which are observable. Outcomes are defined as changes in relationships, activities, behaviour or actions of the people involved: individuals, groups, and organisations with which a program works directly. Based on this definition, outcome challenges aim at describing how the behaviour, relationships or actions of an individual, group, or institution will change if the program is (extremely) successful.

Outcome Challenges

The TGH Program encompasses the Canadian-based team AND four country team members AND their partners, all working together towards ten main outcome challenges:

(a) developing sustainable partnerships with government institutions, NGOs, and individuals working in mental health;
(b) gaining the trust and recognition of partners so that it can contribute constructively to debates and decision-making processes in mental health at various levels;
(c) establishing a minimum administrative structure to make the mission operational;
(d) upgrading research capacity and research skills for conducting clinical, psychosocial and ethnographic studies;
(e) developing effective and culturally sensitive mental health interventions combining professional with local knowledge and practices;
(f) generating innovative training materials for effective training and mentoring of health workers and health professionals;
(g) developing evidence-based and culturally appropriate training programs at all levels, using distance learning strategies and continuing education programs;
(h) providing guidelines for public health policies and designing innovative models of intervention at local, regional and national levels;
(i) making acquired knowledge available to policy makers, planners, administrators and health providers in the governmental, non-governmental and community sectors;
(j) promoting gender equality and gender-based comparative framework.

Progress Markers

We developed progress markers for each of the outcome challenges presented above in order to identify and outline the incremental degrees of change leading to the

achievement of outcome challenges. Individually, these progress markers can be considered as sample indicators of behavioural change, but their real strength rests in their utility as a set. Cumulatively, they illustrate the complexity and logic of the change process. In order to assess the progress markers, we ask each TGH country team leader to complete a questionnaire having specific questions for each progress marker. The filled-in questionnaires are included in Annex 3. Since this is a mid-term evaluation exercise, we did not include all outcome challenges and its respective progress markers. Instead, we focused on progress markers outlined in the year-1 and year-2 TGH Program original proposal.

List of progress markers

1. Establishing partnerships with: a) government institutions; b) NGOs; c) individuals; and d) others (i.e., academic institutions, international agencies, professional associations, networks, etc.).
2. Ensuring/identifying similar goals with your partners.
3. Holding meetings with your partners.
4. Consulting and exchanging information with partners.
5. Participating in events organized by partners or others.
6. Establishing an administrative structure.
7. Developing a good understanding of the program's administrative regulations, including financial issues (e.g. budget, accounting, financial reports, reimbursements of expenses, etc.).
8. Procuring external funding from other sources for developing mental health programs and interventions.
9. Searching for relevant scientific/advocacy literature (books, journals, grey literature, periodicals, audio and visual materials, etc.).
10. Systematizing and organizing documents/publications.
11. Distributing scientific/advocacy literature to potential users.
12. Participating in the first and second McGill International Courses.
13. Selecting students/staff eligible to McGill fellowships (1 month and 3 months).
14. Exchanging education/technical support/information with Douglas-McGill.
15. Setting-up the research agenda.
16. Complying with ethical principles of research.
17. Selecting research sites.
18. Training field workers.
19. Collecting data and analysing.
20. Presenting research findings to community leaders and other stakeholders.
21. Presenting research findings at (scientific) meetings.
22. Disseminating research and program advances to public media and/or other publications.
23. Submitting manuscripts about research findings and program status to scientific journals.
24. Promoting gender equity.
25. Describing how structural/power discrepancies in gender relations influence TGH related activities.

MTE Questionnaire

The MTE questionnaire was generated based on the identified outcome challenges and respective progress markers (Annex 2). By asking for specific information for each progress markers, the aim was to monitor achievements toward the desired outcomes. Since promoting gender equality and gender-based comparative framework are crucial components of the TGH program, we encourage our partners to address these issues in answering the questions. In addition, an outcome challenge (j) was incorporated at the end of the questionnaire that focused specifically on gender.

For obvious reasons, three outcome challenges were excluded at the time of the Mid Term Evaluation (March 2009): (f) generate innovative training materials for effective training and mentoring of health workers and health professionals; (g) develop evidence-based and culturally appropriate training programs at all levels, utilizing distance learning and continuing education programs; and (h) provide guidelines for public health policies and designing innovative models of intervention at local, regional and national levels.

The MTE exercise encompassed the first two years (24 months) of the TGH program implementation, from April 2007 to March 2009. The estimated overall percentage of implementation has been high in those centrally (Douglas-McGill) planned activities (over 90%). Furthermore, the TGH program was successful in mobilising the financial resources as requested by the participating countries, as well as establishing the necessary accounting procedures and financial reporting as required by TGH program management.

Mid-Term Evaluation Results

The global context

Despite important advances made in reducing disease and death and developing cost-effective interventions, many problems remain unsolved in the global health and disease equation at the beginning of the XXI century. As a result of the epidemiological transition, “new” patterns of morbidity and mortality have emerged: the increased importance of mental and behaviour-related conditions (i.e., mental illness and neuro-psychiatric disorders, alcohol and substance abuse, self-inflicted injuries, including suicide and deaths from violence and external causes), the threatening AIDS pandemic, the resurgence of “old time” diseases such as cholera, malaria, dengue and tuberculosis within specific regions and populations, the obesity epidemic and the increasing prevalence of diseases of affluence, all represent major new challenges for the global health research agenda. Today, globalization *and* fragmentation are world dominant forces at play, simultaneously exerting major influences in the configuration of vast social sectors, realigning political fronts, generating alliances and antagonistic tensions and conflict in various forms with a range of consequences in the quality of life, health status and life expectancy of populations around the globe. Growing interdependence, competition for world markets, the expansion of transnational corporations, and new trade agreements mobilizing financial resources, goods and services along with increased transfer of medical technologies, drugs and pharmaceuticals, have contributed both positively in some instances, but also negatively to

global health. The trans-boundary movement of hazardous products and waste have created new health risks often resulting in global environmental degradation: ozone depletion, climate change and ocean pollution, with obvious deleterious consequences in the living conditions and global health outcomes.
The realignment of political and economic forces have increased social inequalities and debilitated the safety net, while ethnic and religious conflicts and wars have become major causes of suffering, general ill-health, and increased mortality rates. In recent decades, the number of forcibly displaced and refugee populations have significantly raised to over 30 million, as war, armed conflict, and political upheaval engulfs civilian populations worldwide, contributing to a lingering additional burden of disease, death and disability (Pedersen, 2002; 2003; 2008). Violence has become endemic in many parts of the world. According to a WHO report, in 2000 an estimated total of 1.6 million deaths were attributed to global violence in various forms: about half were due to suicide (self-directed violence), almost one third to homicide (interpersonal violence and crime), and one fifth were war-related casualties. Interestingly, the vast majority of these deaths occurred in low and middle-income countries and less than 10% in high-income countries.

The four LMIC countries (Guatemala, Nepal, Peru and Sri Lanka) involved in this global health research initiative share a history of colonization or monarchy and dependency, the presence of sizable indigenous groups and different ethnicities and languages, and distinctive social, political, religious and cultural attributes. All four countries have in common large segments of the population living below the poverty line, persistent social inequalities, exclusionary practices against women and indigenous peoples, a history of racism and discrimination against ethnic groups, poor governance and corruption at various levels, an inefficient justice system, and above all an experience of both episodic natural disasters (i.e. earthquakes, hurricanes, tsunami, tornados and floods) and protracted and endemic political violence, armed conflict and war. Civil wars may increase the risk of death and disability through the breakdown of the social order, leading to significant increases in interpersonal violence, abuse of women and children, homicide and suicide, mental illness (depression, anxiety and trauma-related disorders), alcohol and substance abuse, accidents and injuries from external causes (Pedersen 2002; 2006), as well as infectious diseases (i.e., malaria and tuberculosis, STDs, cervical cancer, and HIV/AIDS) (Ghobarah et al 2003; Parker 2002; Elbe 2003). These problems are compounded by displacement of large populations who may be exposed to collective violence and also to various forms of exploitation and discrimination, assault; rape and sexual abuse in the often harsh conditions of the sheltered zones or camps where they seek refuge (UNICEF, 1996). The continued instability, uncertainty and adversity of social conditions prevailing in countries undergoing protracted conflict and collective violence exact, directly or indirectly, a severe toll in the health status of local populations. In *Guatemala*, the war has exerted negative psychosocial repercussions at the individual, family and societal levels. Despite having signed the 1996 Peace Accords to end 36 years of internal conflict, the levels of interpersonal violence, homicides and suicides, abductions and other abuses of human rights have increased exponentially in recent years and most of the peace accords remain unfulfilled. Each day an average of 30 persons are being killed in different acts of violence reaching tolls even higher than the internal

armed conflict. Everyday two women are brutally killed in Guatemala, without almost any efforts to stop it or find the perpetrators.

The provision of mental health services to the survivors of political violence and their relatives is part of these commitments that are still waiting to be addressed. After the Internal Conflict was over in 1996, reconstructing the social fabric of the country has become one of the main issues the country is facing. When massive trauma stems from human conflict, the moral fabric of society may unravel, undermining individual and collective processes of peace-building and recovery.

In *Nepal,* after the collapse of the monarchy and the Comprehensive Peace Accord between seven parties and the Maoists was signed on April 2006, the political situation has remained turbulent and the new government is facing major challenges. Nonetheless, the conflict related incidents such as abduction, killings and extortions are continuing especially in the Terai region and among ethnic Tharu groups. According to Nepal Human Rights Yearbook 2009, last year, out of the 541 killings reported country wide, 393 occurred in 20 districts of Terai only. Similarly, out of 729 abductions, 432 were from the Terai. Widespread extreme poverty, stagnation in the economic development and massive unemployment, and political infighting among the various factions and political parties, has increased the levels of insecurity and the country seems closer to experience a major humanitarian crisis. Fuel shortages and sustained failures of electricity supply hamper the provision of basic services, including water. Provision of electricity has been reduced to essential services and power is cut country wide for 16 or more hours daily. In the Human Development Index, Nepal has gone further down in the ranking to 142, from 138 last year (UNDP, 2007).

In *Peru,* after the autocratic government of former President Alberto Fujimori tumbled down with charges of corruption and abuse of authority, the process of democratization has continued to move forward and overall political situation has remained relatively stable. It has been 5 years since Peru's Truth and Reconciliation Commission (TRC) submitted its report on the political violence that wracked the country for two decades, resulting in a death toll of about 70,000 (mostly indigenous peoples) killed or disappeared and more than 600,000 displaced. The members of Peru's TRC emphasised that not only the problems of political violence remain unattended but underlying problems such as inequality, discrimination on the grounds of race or class, lack of access to services, and land rights, must also be addressed. According to the government commission responsible for following up the TRC's recommendations, it has been estimated in 22,000 families (or 132,000 individuals) as the most vulnerable group directly affected by organised violence which remains without access to any form of mental-health care.

Peru's coastal areas were hit by an earthquake in August 2007. The epicentre was close to an active fault line 200 Km. south of the capital city, Lima, and measured 8.0 on the Richter scale. The quake affected the departments of Pisco, Ica and Chincha, and killed over 500 people, and more than a thousand were injured. In Pisco, more than 52,000 homes were destroyed and 100,000 people were also made homeless. Despite the considerable relief effort, the initial response was chaotic, marked by a lack of coordination and inadequate information on the needs of people on the ground and hindered by a lack of capacity at the regional and central level of the government. The overall situation of most people resident in the affected areas remains precarious. At the time of writing this report, violence broke out in northeastern region of Peru when 2,000

Aguaruna and Wampi Indians, clashed with heavily armed police forces following a highway stand-off near Bagua Grande, roughly 870 miles north of the capital Lima. Official figures put the death toll at just 32, including 23 policemen, but Amnesty International and other observers say the number of deaths is closer to 60, and vast numbers of missing people have yet to be accounted for.
Finally, in *Sri Lanka*, the armed forces launched a massive operation against the LTTE in mid-2008 which forced LTTE militants out from the northern and eastern regions. The LTTE cadres were finally surrounded by Sri Lankan armed forces and confined to a few square Km in the Mullativu district (Northeast), and LTTE militants were killed or captured leading to the end of the war. Massive displacement of civilians, estimated in about 300,000, have been confined to live in temporary shelters and refugee camps creating a complex humanitarian emergency of vast proportions. The escalation of the war and the forced displacement of people have created security concerns which continue to prevent free access to the northern region. The massive internal displacement of people and the refugee camps in Vavuniya will have negative repercussions in the region and the intended study on the wellbeing of communities affected by conflict and the tsunami in Jaffna may have to be abandoned, as the focus of the TGH program in the next two years shifts to other priorities.

Trauma & Global Health (TGH) program: centrally-planned activities.

The following section lists all centrally-planned (Douglas–McGill) activities supported under the TGH program during the reporting period (April 2007-March 2009), which corresponds to the first (Y1) and second year (Y2) of operations. There is no distinction made between R&D, CB, and KTE program components, since most of the reported activities have multiple and overlapping purposes. Unplanned activities are reported as such, with dates, but no percentage of accomplishment is given (NOTE: for additional details please consult the Y1 and Y2 Progress Technical Reports).

List of main activities:

1. Preparatory activities: signature of the MGC (March 2007): the Memorandum of Grant conditions was signed between McGill University and IDRC, on March 2007.

2. TGH Program setup: Establishment of Management and Joint Executive Committee meetings (100%) (March 2007).

3. TGH Program setup: Administrative meetings held in Montreal and all 4 partner countries (100%), (various dates).

4. TGH Program setup: recruitment and selection of research assistants (100%), (various dates).

5. TGH Program setup: First TGH Joint Executive Committee meeting (100%) (March 6, 2007).

6. TGH Program setup: Signature of country partnership agreements (100%) (May-July 2007).

- PA was signed with People's Rural Development Association (PRDA) / Initiative in Research and Education for Development in Asia (INASIA), in Colombo, Sri Lanka (May 2007).
- PA was signed with Centro de Investigaciones Biomédicas y Psico-sociales de Guatemala S.A (CIBP), in Guatemala City, Guatemala (July 2007).
- PA was signed with Centre for Victims of Torture (CVICT), in Kathmandu, Nepal (July 2007).
- PA was signed with Facultad de Salud Pública y Administración (FASPA) - Universidad Peruana Cayetano Heredia (UPCH), in Lima, Peru (August 2007).

7. First Annual Management Committee (MCM) and Executive Committee (ECM) Meetings (100%) (March 26-28, 2007).

8. Training at McGill (CB): Fellowships/Scholarships and Awards (100%).

- Fellowships/Scholarships: selection and allocation of 2 full fellowships (one Sri Lanka and one Nepal) and one half fellowship (Sri Lanka).
- Awards: 2 small grants were awarded to McGill students during this period.

9. Design and construction of TGH web portal (100%) (September 2007).

10. Design and production of other teaching-learning materials (100%) (various dates):

- CD-ROM “Rethinking trauma: Social, Cultural and Psychological Perspectives”.13th Annual Summer Program in Social and Cultural Psychiatry, Montreal, May 7 to June 4, 2007.
- DVD with selected conferences “Rethinking trauma: Social, Cultural and Psychological Perspectives”. 13th Annual Summer Program in Social and Cultural Psychiatry, Montreal, May 7 to June 4, 2007.
- CD-ROM “Mental Health Practice & Research Training Course and Workshops. Second International Global Mental Health Course, Colombo Sri Lanka January 21-26, 2008.

11. TGH Program setup: First TGH team Global Video-Conference (50%) (October 5, 2007).

12. First International Global Mental Health Course (Trauma and global health. Qualitative methods) in Guatemala City, April 2007 (100%).

13. McGill 13th Summer Program in Social and Cultural Psychiatry in Montreal, Canada, May-June 2007 (100%).

14. McGill Course Rethinking Trauma: Social, Cultural and Psychological Perspectives in Montreal, May-June 2007 (unplanned activity).

15. IDRC and CCGHR Teasdale-Corti Team Leaders Forum (unplanned activity) (held in Ottawa, Canada, November 7th- 9th, 2007).

16. Second International Global Mental Health Course (Introduction to Transcultural Psychiatry, Trauma and Global Health. Qualitative Methods) in Colombo, Sri Lanka, January 21-25, 2008 (100%).

17. Site visits in year one (100%):
- Guatemala: April 20-25, 2007.
- Peru: July 18-31, 2007.
- Peru: September 17-25, 2007. Following the earthquake of August 15, 2008, 200 Km south of Lima Metropolitana, a visit to the most affected areas was organised with M. Piazza and D.Pedersen, with MOH officials and other local NGOs to assess the training needs and other earthquake-related issues in the Sur Chico (Pisco, Chincha and Ica).
- Sri Lanka, January 17-27, 2008.
- Nepal, January 28 - February 13, 2008.

18. Fellowships/Scholarships and Awards (100%): a total of one fellowship (one month) and one scholarship (three months) have been awarded during the first year) In addition, two TGH small grants were awarded to Canadian-based candidates to complete field visits for training and data collection.

19. Second Annual Management Committee (MCM) and Executive Committee (ECM) Meetings (100%) (April 27-30, 2008).

20. McGill 14th Summer Program in Social and Cultural Psychiatry and Advanced Study Institute in Montreal, Canada, April-May 2008 (100%).

21. McGill Seminar on Rethinking Trauma: Social, Cultural and Psychological Perspectives in Montreal, Canada, May 2008 (100%).

22. Third International Course in Trauma and Global Health (Introduction to Transcultural Psychiatry; Trauma and Global Health), in Kathmandu, Nepal (100%), March 2-9, 2009.

23. Congress of the Central American Association of Psychiatry, in Guatemala City, March 16-21, 2009 (unplanned activity).

24. Intensive course using qualitative methods in health research, in Guatemala City, Guatemala, March 2009 (unplanned activity).

25. Distance E-Learning (DEL) Course on Global Mental Health and Trauma-related disorders (10%): the preparation of a DEL Course on Global Mental Health and Trauma-related disorders remained behind schedule and it may have to be suspended indefinitely.

26. TGH Program setup: recruitment and selection of research assistants (100%) (various dates).

27. Feature Interview on IDRC Website (unplanned activity).

28. The Trauma and Global Health Program Conference Series, in Montreal, February 17th 2009 (unplanned activity).

29. Newsletter (unplanned activity) (issues published: June and October 2007, March 2008; June and October 2008, and March 2009).

30. Web access to McGill libraries for TGH country partners was extended (100%).

31. Updating of TGH web portal (100%) (various dates).

32. Site visits (100%):

- Lima, Peru, 17-29 August, 2008.
- Guatemala, November 24 - December 2, 2008.
- Kathmandu, February 23 – March 10, 2009.
- Guatemala, March 15 – 22, 2009.
- Lima, Peru, March 30 – April 7, 2009 (Y2-Y3).

33. Midterm evaluation: The TGH program conducted a mid-term evaluation (Y1 and Y2) using an Outcome Mapping (OM) evaluative strategy (100%). February-April 2009.

Results of the Outcome Mapping

Most of the planned research and documentation activities (R&D) at the country level have been completed in Sri Lanka and Nepal, and are being completed in Guatemala and Peru, all of which have been reported in the annual progress reports and in the MTE country reports (see below). The capacity building (CB) component has been executed according to plan, with the exception of the distance education learning (DEL) course. There have been a significant number of unplanned CB activities conducted at the country level (see below). The knowledge transfer (KTE) component has been successfully initiated with periodic email exchanges, one-on-one video-conferences, updating of the toolkit, electronic access to McGill libraries and the newsletters, most of which has been supported with the production of CD-Roms and consolidated with the periodic updating of the TGH website (www.mcgill.ca/traumaglobalhealth). The website features a Resource Centre with a large collection of video and audio materials as well as a Tool-Kit and bibliographic references (in English and Spanish) made available to TGH teams and McGill students.

In the next section we will present a summary of the results of the outcome mapping exercise, according to the seven outcome challenges which were selected.

Outcome challenge (a): Developing sustainable partnerships

Working in volatile and highly unstable and insecure environments, where extreme forms of violence have been rampant --such as the ones prevailing in the selected countries— represent major risks and posit extraordinary demands on part of all the agencies involved as well as on the Douglas-McGill-based researchers and their partners.

In spite of extremely adverse conditions, all country teams were successful in establishing multiple partnerships with local community-based organizations, peer agencies and local NGOs, academic institutions, governmental and private service delivery organizations.

Partnership agreements between the Douglas Institute-McGill University and all four TGH country teams were signed in the first trimester of TGH program operations and with the exception of a brief (3 months) interruption with the Peruvian TGH team in 2008, periodic and direct interactions, with cordial and sustained exchanges, have strengthen the relations between all partners. In turn -- and this is perhaps one of the most significant accomplishments in all four participating countries -- the number, scope and variety of boundary partners with whom some form of direct interaction was established during early stages of TGH program implementation is remarkable, and in some cases it has been growing to include the national university (such as in the case of the Universidad Nacional San Carlos de Guatemala) and even engage other international organizations which have given additional funding to extend TGH activities (such as the case of Oxfam America in Sri Lanka). Networks and partnerships established were largely grounded and enriched by interpersonal relationships, formal and informal exchanges. At the country level, while the partnerships were initially activity/event based, they gradually grew up into broader arenas of common interest, increasing opportunities for mutual sharing, building trust and confidence, solidarity and cooperation, all of which have lead to positive and in most cases, sustainable partnerships. Sri Lanka and Nepal have established both formal and informal partnerships, and their country networks remained relatively stable in number and scope. Guatemala and Peru experienced oscillations and transitory reductions in the number of boundary partners, but since last year have picked up and the balance at the end of the second year has been a clearly positive one. The current TGH network encompasses a total of 40 researchers mostly coming from the health and social sciences, based in Canada and all four participating countries.

Outcome challenge (b): Gaining the trust and recognition of partners

Mutual trust and confidence between the Douglas-McGill team with the four boundary partners were fairly well established during the preparatory phase, prior to program implementation. In one case (Peru), we have maintained uninterrupted partnership for more than 10 years of collaborative work in mental health. In the case of Guatemala and Nepal, our boundary partners are former graduate students of the McGill Summer Program and have spent sometime attending courses at the Division of Social and Transcultural Psychiatry in the recent past. In the Sri Lankan case, Dr. Suman Fernando

has been a visiting scholar to the McGill Summer Program for many years, and was instrumental in establishing the linkages with our boundary partners in Sri Lanka, with whom we have established collaborative relations at an early stage prior to the beginning of the TGH program. Our relations with the boundary partners have been maintained and strengthened through site visits, the international courses, the continuous exchange of information(technical and administrative), and the attendance to the McGill Advanced Study Institute and Management Committee Meetings held in Montreal every year. All of these have been reinforced through regular contacts via telephone, videoconferencing and e-mail, formal and informal meetings, and joint field visits with the country partners.

Outcome challenge (c): Establishing a minimum administrative structure

There are two simple structures for planning, co-ordination, implementation, monitoring and evaluation of the TGH program: a Management Committee (MC) and a Joint Steering Committee (JSC). Membership of the two committees was recruited from the Douglas-McGill faculty and staff and country TGH leaders from each of the four partner institutions. The Management Committee (MC), composed by 7 members (3 Douglas-McGill, plus 4 from country partners), is involved in policy development and priority setting and have meet once a year at the end of the fiscal year, in April, in the city of Montreal. It is responsible for the formulation and approval of a detailed annual work plan, resource allocation and approval of the annual budget (global and country level). The MC is also responsible for the monitoring the process of implementation and evaluation of project outputs. The JSC meets 3 or more times a year, and is in charge of reporting activities (including the preparation of progress and financial reports) in collaboration with the appropriate administrative units at the Douglas Institute and McGill University.

A Memorandum of Grant Conditions was signed between IDRC and McGill University in March 2007 and the basic administrative procedures were agreed between McGill University and the Douglas Mental Health University Institute. Before the initiation of program operations in the respective countries, the Douglas-McGill signed a Partnership Agreement with each partner institution, stipulating the conditions and requirements to insure effective implementation of the TGH program objectives and annual work plan, as well as contributions expected and other institutional details for managing financial resources allocated to each research team. The research teams and the partner institutions at the four countries involved have different levels of experience in managing external funds and have established different administrative structures in charge of managing the program funds. Three countries have NGOs as partners --ranging from two relatively large organizations: CVICT in Nepal and PRDA in Sri Lanka to a bare minimum in a relatively new NGO such as CIBP in Guatemala. In Peru, the administration was assumed by the general administrative office of a large private University (Universidad Peruana Cayetano Heredia). Early in the first year country visits were made by the TGH Program Manager to all four partners in order to secure the accounting services and other basic administrative support will be available in all four country sites. Standardised, but flexible and decentralized management procedures for fund allocation and reporting of expenses have been established jointly with the country TGH team leaders.

Outcome challenge (d): Upgrading research capacity and research skills

In this section we outline the research driven initiatives and the exchanges between TGH country team leaders and Douglas-McGill team, as well as tutoring and academic support received from various sources, including the Douglas Institute and McGill University. The ongoing research agenda has been developed through discussions with each TGH team member during the preparatory phase and subsequent site visits of the Douglas-McGill team, including: selection of country sites and target populations, discussion of research priorities and development of research protocols, solving methodological issues and ethical considerations, orientation in the analysis of the data, and peer review of draft reports and manuscripts submitted for publication. The specific research protocols developed in each country reflect key issues as identified by TGH country teams. Detailed research protocols on each of the proposed research topics were developed through close collaboration between the Douglas-McGill team and the TGH country team leader. This process of protocol development and methodological design has proven to be a crucial part of the capacity building process. TGH country team leaders and their partners have benefited from the tutoring and support received from the Douglas-McGill team at various stages of the research cycle. Literature reviews conducted at McGill or using the McGill Libraries proved essential in improving the quality of research designs, funding proposals and preparation of reports and manuscripts for publication. Relevant articles identified through search engines were disseminated at workshops through CDs, as well as in photocopies and PDF files. The courses and workshops in qualitative methods given in Sri Lanka and Guatemala as well as workshops in data analysis using software (AtlasTi) were rated as highly relevant. In addition, the TGH website, under the Resources Centre tab, offers free access to a great variety of documents in English (and some in Spanish), articles, video-documentaries and links on relevant subjects aimed at graduate students and researchers.

However, TGH country teams have made variable use of all these resources: Sri Lanka and Guatemala have average to high levels of utilization, while Nepal and Peru have made much less use of the resources available. Limiting factors are language (Peru), as all bibliographic resources are in English or French and also lack of high speed connectivity and power cuts (Nepal). Demands for administrative information and managerial support have been high in Peru and Guatemala and lower from Sri Lanka and Nepal. The Guatemalan TGH country team established a Documentation Center called Centro de Apoyo a la Investigacion (CAI), in partnership with the Masters' Program in Social Psychology and Political Violence at the Universidad San Carlos de Guatemala (USAC-MDPSPPV). The CAI consists on a documentation centre holding the collection of master thesis, and a computational center with specialized software for data analysis (quantitative and qualitative), and access to the McGill University online resources. The last stage will acquire books and printed journals to expand the current collection.

Outcome challenge (d1): Conducting research

The TGH Program is, by the very nature of the enquiry, a high risk enterprise. It entails a high level of personal and institutional risk, and given the context of conflict and, in some cases, organised violence and open war between two or more factions, including the government, the armed forces and the presence of rebellious groups, implies a high level of insecurity which may result in life threatening situations for all resident researchers. At

the same time, most if not all the information being collected is extremely sensitive and confidential, and it may compromise the life and well being of the people involved unless specific security measures are taken.
All research protocols have been submitted to local ethical review boards and/or community prior consent prior beginning the data collection. In Nepal and Sri Lanka there seems to be fewer restrictions in conducting field research and ethical clearance is often not required or simply omitted. Field work will be preceded by further community work with partners and stakeholders, bringing together communities, focus groups, key-informants, and other stakeholders to share their experiences, aspirations, and perceptions. Local advisory boards will be constituted to insure conformity with indigenous values and practices and to participate in the knowledge creation and translation process. In addition to English, local language has been used for interviews according to respondents and informants' preferences. Provisions were taken ensuring informed consent of all participants, and preserving confidentiality and anonymity of respondents. Fellows participating in McGill Summer Courses received training in the construction of questionnaires and qualitative interviewing techniques.
While Sri Lanka and Nepal did complete the quota of candidates for the Summer Course, Peru is in the process of pre-selection and Guatemala has not initiated the selection of candidates yet.

Outcome challenge (i): Making acquired knowledge available at various levels
There is yet no clear understanding of the dynamic process between new knowledge-innovation to its adoption and application, and we are just beginning to understand better the forces at play in changing the model of clinical practice. The processes from knowledge generation to application are complex and influenced by many factors, including the local context (where practices take place) and the perceived relevance of new knowledge to its practical application and use. Various sources of knowledge -- besides that from research and the scientific endeavour– are needed by various users ranging from policy makers, to practitioners to managers and communities.
Initiatives to disseminate research results to the participating communities were carried out in Guatemala, Peru and Sri Lanka. The dissemination of research results at other levels have been made by Sri Lanka, including the dissemination and publication of research results. Guatemala, Peru and Nepal have not completed the analysis of their data sets and therefore have made no reports, neither submitted articles for publication.
We acknowledge the importance of combining both popular and scientific knowledge as a prerequisite for an effective KTE. Yet we lack frameworks and platforms for effective dissemination and application of knowledge at all levels. The CB and continuing education strategy under implementation in the TGH Program is an attempt to address the needs of one key group of research users: the clinical and public health practitioners working in post-conflict/disaster situations and/or mental health institutions, such as Teaching Hospitals and academic programs (Psychiatry, Psychology, Public Health, etc.).
We are beginning to use different KTE strategies to reach the various stakeholders and research end-users, emphasizing participatory action approaches (Sri Lanka), and addressing the challenges imposed by working in often turbulent and adverse environments such as post-conflict/disaster operations and resource-poor settings (Peru, Nepal, and Guatemala). At the time of preparation of this MTE report, Nepal and

Guatemala, in collaboration with the Douglas-McGill team, have completed a planning exercise on Knowledge Transfer and Exchange which has been submitted to IDRC for funding.

Capacity building

In Montreal, training was based at McGill University and two major McGill-affiliated Hospitals consisting of the following specific activities: (a) co-applicants, collaborators and students from Canada, and fellows from Nepal and Sri Lanka have participated in the annual McGill Summer Program in Social and Cultural Psychiatry, which includes graduate level seminars and workshops on cultural psychiatry, trauma and recovery, psychiatric epidemiology, use of quantitative and qualitative methods in cross-cultural research and community-based participatory action research; (b) participants also have taken part in the McGill Advanced Institute in Cultural Psychiatry on themes related to ongoing McGill faculty initiatives (e.g., Peace, Conflict and Reconciliation); (c) In-service training: selected trainees and volunteers from Canada and other countries have been working in literature reviews, protocol development and research methodology under the tutorship of McGill faculty based at the Douglas Institute and Jewish General Hospital; (d) one trainee from Sri Lanka with clinical expertise participated in the activities of the Cultural Consultation Services, learning the use of the Cultural Formulation and strategies for working with culture-brokers. Throughout these activities, trainees have received mentorship for their research projects integrated within the larger research program of TGH country teams.
The McGill team started the organisation of the DEL Course by a) preparing a course outline and reading list (homologous to the Summer Course on Trauma and Recovery with global mental health content in addition); b) exchanging information with an expert for technology mediated teaching and learning at the Department of Education, McGill University; and c) reviewing computer conferencing/computer technology and other media such as texts, videotapes, DVDs, etc. as well as software available at McGill (see myCoursesWebCT). At the present time, myCourses (WebCT Vista), McGill University's learning management system, is used in approximately 1500 courses per term by thousands of students in Quebec and Canada. McGill registered students automatically have access to the courses in which they are formally enrolled. However, McGill courses use WebCT Vista in a hybrid or blended fashion, most often as a supplement to classroom-based instruction requiring prior official approval by McGill, including the authorization to become an official instructor, which represents an important constraint for the DEL Course, which is aimed at international students not regularly enrolled at McGill and without access to McGill IT (internal) resources. We are exploring other alternative platforms, such as Moodle, but this may require finding additional financial resources for design and construction of the DEL Course.

Outcome challenge (j): Promoting gender equality

In each of the four LMIC country sites women have borne the brunt of armed conflicts and disasters as part of disempowered ethnic and social groups in conflict. For example in Nepal, Maoists have capitalized on the plight of women, who have been marginalized for decades in Nepalese society and enrolled them into the conflict in large numbers. It has been estimated that approximately one third of all Maoist rebels were women (Maskey, 2003; Pettigrew & Shneiderman, 2005). Social inequalities, poverty and war have contributed to an increase in the trafficking of Nepalese women and girls; it is

estimated that each year 5000 to 10,000 Nepalese females are abducted into Indian brothels (Mishra, 2005). During the 36-year long "low intensity" war in Guatemala there were over 200,000 people killed or disappeared, and between half a million and 1.5 million people internally displaced, the majority of whom were women. More than 80 percent of the victims of war were of Mayan origins and women were a clear majority among survivors. The estimated number of war orphans (from one or both parents) is about 200,000, and widows are at least one third of that figure (Wearne, 1994). More recently, women in Guatemala City have been targeted and brutally murdered.
In a survey conducted among Quechua populations in the Peruvian highlands, the most affected people, as measured by the presence of trauma-related disorders such as PTSD, were adults over 50, mostly women with no schooling, widowed or separated and with little or no stable source of income .
War and low intensity conflicts had a range of negative impacts exacerbating social inequalities at all levels, particularly in rural areas, where most of the conflict has been concentrated. In Nepal, there continues to be minimal inclusion of women in all leadership positions, including political appointments in government, a situation which applies to most other LMIC countries.
In all four countries the issues of gender have been addressed to some extent, as explained in the TGH country reports. The social science literature has shown that in societies where violence has become a norm — like war or low-intensity conflicts— higher rates of interpersonal aggressions are expected to follow. Women are exposed to additional and exceptional trauma risks during and following conflict, in refugee camps and during transit, including various forms of interpersonal violence: rape, incest, forced marriage and body mutilations, unwanted pregnancies, gang rape, sexual slavery, sexual work and sexual abuse and exploitation.
There seems to be consensus that one vital factor explaining why women tend to be targeted is because of their central role in maintaining social cohesion at all levels. Often, such forms of interpersonal violence have been intentional socio-political tactics integrated within an overall war fighting strategy, aimed at inflicting further damage to the enemy by degrading and demoralizing women and their communities. The intentional targeting of women by structurally integrating violent practices against women into military doctrine as a way to attack the "will to fight" in an "enemy collective", has become a pervasive part of military strategy. The attacks on women are therefore an attack on the collective ethos using sexual aggression as one of the most pervasive form of violence. Vulnerable groups at particularly heightened risk for violence include adolescents, pregnant/breastfeeding women, disabled and elderly women. While there are substantial variations in how cultures define gender roles, in most of the partner countries the identity, social status and roles of women emphasize their relational linkages with their father, husband, and children. The loss of one of these social anchors through war or natural disaster may be devastating to women's social status and identity, placing them at high risk for psychological distress. Widowhood (as in the case of Guatemala and Peru), loss of loved ones, grief and social disruption, displacement and loss of livelihood (as in Sri Lanka), and forced conscription as soldiers or military service (as in Nepal) all impose an additional health burdens on women and adolescents. Excess deaths among women have been well documented following many natural disasters such as the cyclone that hit Bangladesh in 1991 or the tsunami in Sri Lanka in 2004.

Women who are exposed to trauma often suffer poor mental health outcomes, including increased rates of depression and anxiety, trauma-related disorders, alcohol and substance abuse, medically unexplained somatic symptoms such as pain and poor subjective health as well as other health problems like sexually transmitted diseases and unwanted pregnancies. Emergency management agencies and others responsible for emergency relief such as first responders, fire personnel and law-enforcement agencies are primarily staffed by men; thus, relief and recovery efforts such as the case of the Peruvian earthquake of August 2007, tend to overlook women's specific needs. It is of critical importance women be included as leaders in planning and implementing projects and interventions which will affect their physical and mental health. To access women's perspectives on the mental health consequences of war conflicts and natural disasters, it is necessary to include a gender-based comparative analysis. This comparative analysis would take into account the differential impact of social contexts on men and women by considering gender relations as an organizing principle of political, social, economic, and ethical spheres. Because of societal class structure prevailing in countries such as Nepal or Peru, this comparative analysis must also consider how race, ethnicity, age, geographic location and schooling interact with gender. In all four participating countries, there has been little systematic attention paid to the differential impact of trauma on both men and women, which remains a essential ingredient for planning and implementing culturally appropriate and effective interventions in physical and mental health.

Midterm-evaluation: GUATEMALA

Context

The Trauma and Global Health (TGH) research program aims to reduce the mental health burden of populations exposed to protracted violence and episodic natural disasters, foster the process of healing, psychosocial rehabilitation and recovery, and generate improved mental health policies and services in the participating countries. The program aspires to build a sustainable research environment in partnership between McGill University with research teams and their host institutions in Guatemala, Nepal, Peru, and Sri Lanka.

This GHRI Teasdale-Corti Team Grant will contribute to rethinking humanitarian responses and strategies for healing and coping by moving beyond the narrow psychological focus to a wider perspective of the social and cultural context in which people live, cope with and recover from potentially traumatic experiences. The TGH program's 3 main spheres of action are: i) Research and Documentation; ii) Capacity Building and iii) Knowledge Transfer

Guatemala is a multicultural and multilingual country (4 distinct ethnic groups and 24 different languages) that gives the country an amazing diversity, but at the same time makes a real challenge to reach consensus to address the common problems. From 1960 to 1996, Guatemala lived a "low intensity" war with a terrifying outcome of over 200,000 people killed or disappeared, between half a million and 1.5 million people internally displaced or fled the country and started to come back just before the place was signed, more than 80 percent of the victims of war were indigenous Mayan people.

The war had psychosocial consequences at the individual, familiar and social level, and was strong enough to destroy the country's social fabric. Despite having signed the 1996 Peace Accords to end 36 years of internal conflict, violence and abuse of human rights are still present in Guatemala and most of accords remain unfulfilled. Mental health attention to these victims of political violence and their relatives is part of these commitments that are still waiting to be addressed.

After the Internal Conflict was over in 1996, reconstructing the social fabric of the country has become one of the main issues to face. When massive trauma stems from human conflict, the moral fabric of society may unravel, undermining individual and collective processes of recovery.

Main achievements Y1 & Y2

The first two years for the Guatemalan TGH Program, have been a challenging but at the same time a rewarding experience. Although we had an unavoidable delay on our planned activities for year one, we were able to catch up in most of the projects, during the second year. We believe that our main achievement for these first two years has been the **"**social capital**"** that we have generated. Even when CIBP is still a small institution, the number and quality of the partners working with us, have created an important network that made possible to articulate efforts for the local program success. In that sense we have established partnerships with one government institution (The National Mental Health Program, Ministry of Health –NMHP-); three NGOs (The Center for Forensic Analysis and Applied Sciences –CAFCA-, Barefoot Doctors Guatemala, -MEDES- and Women NGO Ajpu) (see Annex G1); one individual (Patricia Foxen PhD)

and six organizations from the academia, professional associations, networks, etc (Guatemalan Mental Health Network –RNSM-, The Masters Program in Social Psychology and Political Violence, Universidad de San Carlos de Guatemala. -MPSPPV/USAC-, The Universidad de San Carlos Extension Program -EPSUM-USAC-, The Center for Health Science Research –CICS- Medicine School, Universidad de San Carlos de Guatemala).
We have made significant advances in the three spheres (Research and Documentation, Capacity Building and Knowledge Transfer) proposed on the TGH plan of work:

Research and Documentation

Three research projects and a documentation centre were developed:

a. Idioms of distress and healing practices among indigenous populations lead by Paula Lopez in Chiche, El Quiche conducting over 50 interviews and 5 focus groups. The final report is under review and one paper is expected out of this research project.
b. Psychosocial interventions of forensic exhumations among the indigenous populations of Huehuetenango, this project is in charge of Felipe Sarti and Alfredo Anckermann from CAFCA and the local TGH program PI. So far the project has concluded the first stage consisting in a community approach and initial project discussion with the residents of *Sebep* in the northern *departmento* (district) of Huehuetenango. The researchers have conducted seven activities with community leaders, representatives and other participants as the necessarily step previous to the field work.
c. Gendered responses toward distress and resilience among indigenous men and women Guatemala. The project was led by Patricia Foxen and conducted in Chiche, El Quiche. Twenty in-depth interviews were performed, translated from Ixil and transcribed. The final report has not been yet submitted by Dr. Foxen.
d. Establishment of Documentation Center*:* The Center for Research Support (CRS) was implemented by the TGH program and is currently functioning at the Masters Program in Social Psychology (USAC-MDPSPPV). The CRS consists on a computational center with specialized software for research analysis (quantitative and qualitative), access to the McGill University online resources, book shelves, desks, chairs and other office furniture. The last stage will consist in acquiring more books and printed journals to expand the installed capacity.

Capacity Building

The capacity building activities were developed at different levels:

a. Community level: As an initial stage of our research activities five promoters, 3 women and 2 men, were trained as cultural brokers and in mental health issues in Chiche. In Sebep twelve community members were trained to support the research activities in the project with CAFCA.

b. Medicine Students: Up to 300 last year students have been trained in topics of mental health and mental health research for conducting the National Mental Health Survey.
c. Health Professionals: One of our projects with EPSUM-USAC trained ten professionals on topics of diagnosis and management of main mental and behavior-related disorders, including trauma, alcohol abuse, violence against women, sexual abuse, etc
d. Health Researchers: During the Second International Course, forty-three health researchers from the Medicine School/USAC were trained on Qualitative Methods of Health Research.
e. Other training activities: Several training activities with other partners have taken place: the First International Course trained seventy-five participants coming from different organizations and with different backgrounds, addressing topics of political violence, trauma and mental health. Twenty-four mental health providers working with the NMHP have been trained in identification and management of the most common mental health problems. Several talks have been given to psychology students both at the undergraduate level (about 120 students) and graduate level (20 students) addressing different topics relating mental health and mental health research (Annexes G2-G4).

Knowledge Transfer

Even when the knowledge transfer activities are planned to be addressed with more emphasis during years 3 and 4, we have already developed some activities on this sphere:

a. Mental Health Network: Through our partnership with the Guatemalan mental health network we have support the Third Mental Health fair, consisting in different activities to promote the awareness about the mental health effects of political violence. About 2,000 people attended the two days fair at the Psychology School/USAC.
b. Women NGO Ajpu: Our partners at Ajpu, and NGO based on Chiche, have seen in our research project an excellent opportunity to start the discussion about the mental health consequences of the internal armed conflict in their lives and community. They have shown a vivid interest in discussing the results of our research with them and making it extensive to all the participants as a way of giving back to the community.
c. Dissemination: Many actions have been performed to disseminate our program and activities and aimed at promote dialogue on the mental health issues that we have prioritized. The TGH, has been presented in several local settings (Ministry of Health, USAC, The Pan American Health Organization, etc) and international meetings (Conference “Strengthening Mental Health Research Capacity in Latin America and the Caribbean” Kingston, Jamaica, 3-5 December 2007, The Fifth Summer Institute (SI-5) for New Global Health Researchers, Vancouver, Canada, organized by CCGHR July 2008, The regional meeting for the Central American Psychiatry Association, Guatemala, March 2009. Among others)

Outcome mapping challenges summary

The Outcome Mapping (OM) as an evaluation exercise has allowed us to see our work in different ways; we have been able to identify our strengths and weakness by describing the processes along with the final results. We believe that this process will facilitate us to focus our efforts straight to where they are needed.

We will briefly describe how we place our program in relation with the twenty five OM progress markers; the full OM document contains detailed descriptions of every item.

Outcome challenge (a): Developing sustainable partnerships &
Outcome challenge (b): Gaining the trust and recognition of partners

We believe that one of our main accomplishments is to have generated a very interesting network of partners. This constitutes our social capital and the base of how we articulate our activities and also permit us to participate on their activities. We have a very wide and varied pull of partners coming from different backgrounds and belonging to diverse sectors like the government, the academia, NGO's etc. With many of these organizations, we had some previous work experience, which opened the opportunity to incorporate other partners, from similar fields, to work with us. In that sense, gaining the trust and the identification of common goals was, in most of the cases, a natural process. Having a close relationship with all our partners has been a challenging task for us, nevertheless, we ensure to make the time to meet as frequent as possible. This has been a teaching process that had allowed us to deal with different frameworks and approaches to similar problems. The continuous communication that we maintain with our partners allow us to be aware of their needs, but also the sort of information that they handle and might be useful for us; this facilitates the exchange of information of diverse kind, although we have noticed a lack of a good systematization method which, sometimes, ends up in missing interesting information.

Outcome challenge (c): Establishing a minimum administrative structure

The CIBP is a young research center that undertakes primarily research on mental health, our administrative structure is still small and even when this could be considered one of the down sides of the local TGH program, we have learned that the right functioning of the center depends on a good communication and coordination of the many activities that we undertake. Even when we have acquired several administrative and financial skills, we believe that this is one of the points that we need to improve. The invariable support from the TGH management at McGill/Douglas has been of invaluable help for us, particularly in topics like accounting and financial reports. We believe that obtaining more external funding will help us to consolidate our organization's administrative structure; therefore submitting new grant applications is one of our priorities.

Outcome challenge (d): Upgrading research capacity and research skills

Our research and documentation activities include the search, systematization and organization of relevant literature. This task is one of the assignments that take more of our time. We perform all the searches that our different partners request. The CIBP currently have the only access to the McGill on line resources; we believe that having one

more access permission would facilitate this activity, particularly now that the Documentation Center at the PMPSVP-USAC has been set up with our support; on the other hand, many of the publications that are requested to us are not available on line and are also difficult, to find in Guatemala; this is a critical limitation for us. The TGH Program's manager at the Douglas Institute has been particularly helpful in this point by finding, buying and sending the documents that we are unable to access but this usually takes a longer time and is very expensive. The new Documentation Center is expected to become the core of information on political violence and undertake the organization and systematization of this material.

Outcome challenge (d1): Conducting research

The research activities have followed the research agenda set in accordance with the TGH priorities but also following the priorities of us and our local partners. In that sense, the research procedures such as developing the protocol, selection of research sites, collection and analysis of data, have also been consistently performed with the participation of the partners involved in the particular projects. This point has been sometimes a challenge due to the differences in backgrounds and fields of work among our partners. A good example of this challenge was to set up the topic of complying with ethical principles of research; this approach is still not a concern for the social scientist in Guatemala and we had to start with a dialogue on the matter to set up the right ethical procedures. We are still on the process of writing up the final reports for our research projects but we believe that these products are going to be documents that we can present to community leaders, other stakeholders and general public but also to present at scientific meetings and submit for publications to scientific journals.

Outcome challenge (i): Making acquired knowledge available at various levels

Our capacity building activities have been performed in several ways. We organized two international courses targeted at two different audiences. The first one was open to people and organizations already working on mental health issues; the activity was very successful and was organized with the full support of the National Program of Mental Health and the TGH management at Montreal. The second one was setup in collaboration with the School of Medicine at the University of San Carlos, the activity was targeted to professors and researchers working in different fields; in both courses we had the participation of McGill faculty. Although the main goal of these activities was to build capacity on mental health research, we believe that they also served to consolidate our partnerships with other stakeholders. It is for the first time in the history of the School of Medicine at San Carlos, that their 2009 budget have included certain provisions for funding research in mental health. We have performed other training activities with medical students, health professionals and at the community level. All the activities have been coordinated in close collaboration with our partners. We are still working in the process of recruiting the participants on the McGill fellowship program; this particular point has been difficult to accomplish due, in part, to the lack of the appropriate English skills on our participants.

Outcome challenge (j): Promoting gender equality

One of our permanent interests has been to promote the gender equity in all our activities, nevertheless it is an interesting fact, that the majority of the participants in the TGH activities are women; this aspect is also reflected at the decision-making and execution level; examples of this are: i) the executive director for the NPMH at the Ministry of Health is a women, ii) the director for the MPSPPV/USAC and MEDES are women, iii) the coordinator for the GMHN and Ajpu are both women. Being Guatemala a country with a strong male-oriented culture, assuring a fair gender balance is one of our concerns and best interests.

Conclusions: future directions and challenges

Performing the MO evaluation was an enjoyable experience that allowed us to be aware of our program's current position; but also faced us to our weak points and strengths as a way to focus our next steps. The next two years are going to be devoted to write and disseminate our research findings but also to put the research component into action, by generating effective knowledge transfer interventions to promote the generation of improved mental health policies and services to benefit the Guatemala's people.

Midterm-evaluation: PERU

Context

The Peruvian health sector receives about 4.3% of the country gross domestic product (GDP), which places Peru second from the last amongst the Latin American countries. Mental health is even more neglected as only about 2% of the total health budget is invested in this area while the evidence shows that the group of neuropsychiatric diseases constituted the top cause of burden of disease in Peru. In addition, the concentration of psychiatrists in Lima prompts that a large proportion of the Peruvian population does not have any access or whatsoever to a specialized psychiatric care.

The inaccessibility to mental health services of quality is worsened by the fact that in Peru mental health care delivery is almost completely provided by a small number of specialized institutions with very little participation of primary care institutions. Moreover, community-based mental health interventions are inexistent or in very early stages, and general practitioners still find uncomfortable to deal with mental health problems. Furthermore, mental health research production and results implementation activities are other neglected areas that prevent progress in tackle mental health issues in Peru.

Main achievements

The main achievements of the TGH program in Peru are explained by the activities that were carried out.

a. Post-earthquake intervention: An important achievement of the TGH program was that the Ministry of Health led and organized the response of public and private institutions and organizations regarding the provision of health care and the enhancement of coping mechanisms in the context of the post-earthquake response in Ica. Also this work has taught decision-makers, health professionals and the lay-public about the importance of mental health problems, as well as that they are susceptible to be managed successfully, and thus has contributed in a way to reduce the stigma attached to this problems. Six workshops were carried out to contribute to increase the leadership and organizational response of the Ministry of Health, and the skills of the health care providers, NGO professionals and community leaders to improve the mental health coping mechanisms in the affected places. The first workshop aimed to increase the capacities for planning and organizing the community in a post-disaster scenario, and was held in Lima with a total of 120 attendants, which from the most part came from the affected places (Chincha and Pisco). The second workshop, aimed to strengthen capacities on dealing with mental health problems, was performed also in Lima, with attendants from Chincha (28), Pisco (49) and Ica (58). The other 4 workshops, which were aimed to strengthen community organization capacities, were held in Chincha and Pisco.

b. Violence and resilience study: Qualitative and quantitative data was gathered from two schools in Cusco and two schools in Ayacucho. Specifically, the qualitative data include in-depth interviews to 8 high-school students, 8 teachers and 8 parents, as well as three different focus groups with 12 students, 12 teachers and 12 parents in Cusco

and Ayacucho. The quantitative part involves data from 100 students, 50 parents and 50 teachers. A preliminary written report of the analysis of the qualitative part is available (see Annex P1).

c. Lucanas and Santiago de Vado study: For this study, it was performed 15 in-depth interviews to key informants from both communities, and 5 focus groups in Lucanas and Santiago de Vado. A final report was written. In addition, there has been a meeting to present and discuss with 60 participants the results of the study, which included the local authorities and community leaders. The main achievement is building a relationship of trust with the Municipalities and with the Communities of Lucanas and Santiago de Vado for development of collaborative future interventions. Also women who participated in the study were able to recognize that they also contribute to the development of their communities (see Annex P6).

d. The first mental health international course to train trainers on mental health and community psychiatry: As a result, of the collaborative work between PAHO and the TGH program to strengthen the leadership role of the Ministry of Health in the post-earthquake context, it was developed an initiative to contribute, through training, to the implementation of mental health care at a primary level in the facilities of the Ministry of Health. A first stage of this initiative was the implementation of the first mental health international course to train trainers on mental health and community psychiatry. This course was organized by the TGH program - UPCH, PAHO and the Ministry of Health. 76 participants attended to the course from the Ministry of Health, Ministry of Women and Social Development, NGOs, universities, and churches (see Annexes P2 & P5).

e. The international course on violence and its impact on health: During year two an international course on violence was organized by the National Academy of Medicine, a well recognized institution of physicians in Peru, with the support of the Trauma and Global Health Program. A final achievement of the TGH program was to reactivate the mental health Division of the School of Public Health of Universidad Peruana Cayetano Heredia that has gained again leadership on mental health. In addition a core team of professionals who work in recognized psychiatry institutions, NGOs and Universities meets regularly to provide technical assistance to the activities of the TGH program (see Annex P3).

f. Midterm evaluation – Outcome mapping questionnaire (See Annex OM Peru)

Outcome mapping challenges summary

Outcome challenge (a): Developing sustainable partnerships

During its first stage, the TGH program established partnerships with several institutions to implement its activities. Thus, a collaborative agreement was signed between the institutions who participated in the 2007- post-earthquake activities in Pisco and Chinca (Ica). The TGH program had the vision that the Ministry of health should lead and organized the response, so gave technical assistance for the Ministry of health for it to gain leadership and facilitate its work with the institutions that converged to offer help in the scourged areas. A second partnership was established with the Hermilio Valdizan

Public Hospital that provided technical support to train human resources to strengthen the mental health networks in Ica. In addition, it was established a partnership with the Peruvian National Institute of Mental Health, which was involved in the selection process of the professionals for the fellowships to take place in Douglas Institute - McGill. Also, the TGH program collaboratively work with the Pan-American Health Organization, with which the program joint efforts to coordinate, fund and implement many of the post-earthquake activities (see Annex 4). Another partnership was established with the NGO "Paz y Esperanza," as part of the mental health group, which gave some funding to bring international experts in disasters management. Also, the collaboration of individuals such as Rachael Cohen from the University of Miami, a world expert in natural disaster psychosocial - management, was very important for the organization of the response.
As for the Lucanas-Santiago de Vado study, it was set up partnerships with the corresponding municipalities of both communities that gave political support, presenting the TGH program team to the local organizations, and with the peasant associations, which were very helpful when reaching the potential participants in this study. Also, the partnership with two individuals who were municipality officials in Lucanas and Santiago de Vado was important in easing the implementation of this study. Also, the NGO "AMARES," as finishing its activities in these two communities, facilitate information and support for the evaluation that the TGH program was going to perform to one of the interventions implemented by "AMARES."
In addition, the TGH program procured the support of several institutions (including PAHO and NGOs) to bring international experts in disaster-related trauma issues, and to support operative coordinative work in the post-earthquake activities. For example, TGH program and PAHO joined efforts to make possible that Dr. Hugo Cohen (PAHO – South America) came to Ica to work in community capacity building in a post-disaster scenario. Also, the Centre of Mental Health and Addiction from Toronto gave a scholarship for a course on programs evaluation, which took place in Santiago de Chile that was given to the researcher who is in charge of the evaluation of the distance course on mental health that it is one of the activities of the TGH program.

Outcome challenge (b): Gaining the trust and recognition of partners

In the post-earthquake work, the TGH program held meetings with all the institutions to gather and share information that helped to strengthen networks, identify common objectives across actors and institutions, and helped to organize the efforts to tackle the consensual needs. The information also included technical knowledge about methods to face trauma generated by natural disasters. Some of this information was originally in English, and the TGH program helped to organize the translation of this literature with the participation of graduate students, health professionals, and lay community members. Some of this information has been uploaded at the webpage of the Mental Health and Peace Culture National Strategy of the Ministry of Health.
During the implementation of the Lucanas and Santiago de Vado study, local health professionals, including physicians, nurses and technical personnel, asked for literature about methodologies to deal with mental health problems. They were provided of information developed by previous Douglas institute-McGill-UPCH projects related to violence and mental health. Also, the major of the Provincial Municipality of Puchio (which includes the districts of Lucanas and Santiago de Vado) asked to the TGH

program investigators for information about ways to deal with mental health problems in adolescents. This request has been brought to the TGH program team for discussion and determination of the best way of offering help to this particular request and other requests that may eventually appear as community authorities get sensitized about mental health issues. This information exchange has helped to ensure trust between the local people and leaders and the TGH program investigators.

Outcome challenge (c): Establishing a minimum administrative structure

The TGH program counts with an administrative structure. Also several meetings were carried out to ensure a good understanding of the administrative procedures of the program between the TGH program coordinator and members of the teams in charge of each of the subprojects.

The coordinative role of the TGH program helped to set up common aims and to compromise methodologies across actors and institutions to reach goals, which even included some examples of institutions shifting their own agenda to get engaged in the collaborative work already put in motion under the leadership of the Ministry of Health.

Outcome challenge (d): Upgrading research capacity and research skills

For upgrading capacity for advocacy and capacity-building activities to deal with the post-earthquake scenario in Ica, the TGH program helped to the searching, gathering and adaptation of literature regarding coping with disasters. Some of this information has been uploaded at the web page of the Ministry of Health.

Also, as mentioned above, in Lucanas and Santiago de Vado, mental health literature was distributed among health professionals, including physicians, nurses, psychologists, technicians, and even lay-actors among stakeholders who got interested in receiving information on mental health issues.

For upgrading research capacities, the program has selected a candidate to attend a course on motivational interviewing for alcohol at the Douglas Institute. The selection was performed in a process where participated UPCH, Ministry of Health, National Institute of Mental Health, and Hermilio Valdizan Hospital. In addition, the Peruvian team leader holds regular meetings via Skype with the PI of the program for technical assistance and for exchanging information. Also the PI visited the country on two occasions, where meetings were held with the local coordinator in Peru and with the authorities of the UPCH.

Outcome challenge (d1): Conducting research

In order to set up the research agenda, the team leader arranged a series of meetings with the core team members. These projects were chosen following a compromising between priority and opportunity. After the research agenda was selected, the core team was divided in smaller teams, each of which was in charge of a specific topic. Each team had to write its respective protocol which was then evaluated by the Douglas Institute and McGill for final approval and financing.

The Lucanas-Santiago de Vado and Resilience study protocols were approved by the Institutional Review Board of UPCH and were conducted following the principles of respect, justice and beneficence.

Regarding the selection of the sites for research, Lucanas and Santiago de Vado were chosen because they had been scourged by the political violence in the 80's, but also had available a number of resources as a result of the work of NGO "AMARES." For the study of resilience, 4 schools were selected in 2 cities, Ayacucho that was scourged by the political violence and Cusco that had the highest prevalence of domestic violence.
For the collection of the data, in the Lucanas and Santiago de Vado study, community leaders and municipality officials called to meeting to all community. Investigators took advantage of these meetings to perform focus groups and in-depth interviews, which were performed by investigators themselves. In the resilience study, the instruments underwent a process of face validity. Two field workers were hired to implement this study, who received training by the study in-charge investigator.
A written report of the Lucanas-Santiago de Vado study and a preliminary report of the qualitative results of the resilience and violence study are available.

Outcome challenge (i): Making acquired knowledge available at various levels

The knowledge acquired from the Lucanas and Santiago de Vado study has been presented in the communities where the study was implemented, before municipality officials, health professionals and community leaders. The local audience expressed satisfaction about this TGH program effort of sharing the study results.
Regarding the presentation of activities in scientific meetings, the psychologist Jose Luis Yañez, currently Director of the Chincha-Pisco Mental Health network of the Ministry of Health, presented, in a symposium organized by UPCH on community-based mental health, the experience of the implementation of the activities aimed to strengthen mental health resources to deal with problems in Chincha-Pisco after the earthquake.
Finally, the TGH program helped to carry out a press conference to sensitize to the public about Mental Health and Disasters, which was held in Lima about one month after the earthquake in 2007. In this conference there were about 120 attendants from different backgrounds, including health and education professionals, police and members of international and local institutions.

Conclusions: future directions and challenges

For the next stage of the TGH program efforts will be displayed to help the core team to become a real team with a shared vision and plan of action. Also the communication of the members will be improved by keeping the schedule of regular 2-hour meetings once a month and an all-day meeting every 6 months. The all-day meetings will be specially aimed to plan activities, review final versions of study protocols, papers to be submitted, reports, or grant proposals, for which all members of the core team will make comprehensive presentations of their work to receive feedback from the rest of the group.
Given that the core team is constituted by a multi-disciplinary set of professionals with strong skills in research methods, training and the development of interventions, it can be expected that these short and immersion meetings help to boost the research production of the TGH program and its translation into capacity building activities and knowledge transfer activities.
Also to facilitate communication and collaborative work with the partners, efforts will be put to formalize the partnerships with the signing of agreement letters, especially with Hermilio Valdizan Hospital and the National Institute of Mental Health.

Another future step, it would be to put a special emphasis on writing activities in order to increase the rate of publications in peer review papers as well as in publications in different formats to reach diverse audience such as decision makers, health care providers, mass communication media and mental health-lay actors and their communities.
Finally, a proposal aimed to systematize all the activities that were carried out during the implementation of the post-earthquake interventions is going to be written in order to be submitted it for funding.

Midterm-evaluation: NEPAL

Context

Nepal, after the Comprehensive Peace Accord between seven parties and Maoists on April 2006, is in a state of post Maoist conflict. Nonetheless, the conflict related incidents such as abduction, killings and extortions are going on especially Terai regions of Nepal. In 2008, total 541 killings were reported out of them 393 were killed in 20 districts of Terai only. Accordingly, 729 were abducted and among them 432 were from the Terai and 767 got threatened from state as well as from other groups, according to Nepal Human Rights Yearbook 2009. There were a number of reports of torture .A total of 65 women were raped during the period of 2008. Of the total victims 62 were victimized by others while three were victimized by the security forces (Nepal Human Rights Yearbook 2009). Similarly, 22 women were attempted to rape while 20 women were became the victim of sexual abuses. Children were more vulnerable to sexual abuses. 177 girls were raped during the period of 2008. Of the total victims, one girl was raped by the state security force while rest by other groups. Similarly, 44 girls became the victim of sexual abuse during the period, (Nepal Human Rights Yearbook 2009).

Social Justice and human rights are in shadow even after the Constitution Assembly (Nepal Human Rights Yearbook 2009).The failure of the peace process to address these concerns has resulted in numerous protests and strikes, particularly in the Terai region (OHCHR in Nepal [2008-2009])

The youth wing of the CPN (M), the Young Communist League (YCL), reportedly committed a number of human rights abuses, including abduction and ill-treatment in captivity, assaults and violent disruption of political activities. To counter the YCL other political parties also formed the youth force groups. Some of the expressions and conflict between these forces became violent and created problems to maintain peace and security in state (INSEC Reports, 2007&2009).

There are ongoing agitations in Terai region especially by ethnic Tharu groups. Further, the prevailing poverty and stagnation in development works and volatile political situation is complicating the scenario. The Human Development Index (HDI) ranking of Nepal has gone down to 142 from 138 last year (UNDP, 2007).World Bank (2007 report) declared Nepal one of the poorest country in Asia.

Major achievements

a. Established partnership with different government bodies, NGOs and persons (see Annex N1).
b. Capacity building of 9 field staffs on qualitative and quantitative research methods.
c. Conducted scientific research in three conflict affected districts in 2007/08. A total of 1122 people from different communities participated in the research. (FGD=294; PPA=36; KII=72; Survey=720). We believe that, in the process these research participants got sensitized about psychosocial and mental health care (see Annexes N2 & N3).

d. Developed an intervention called Community Mental Health Promotion Program (CMHP) and implemented in 15 Village development committees of three districts (see Annex N4).
e. Capacity building of 12 field workers on first line psychosocial care and to implement CMHP (see Annex N5).
f. Conducted CMHP in 15 Village Development Committee of three districts where 1399 people directly benefited from the program.
g. Conducted process evaluation of CMHP where 114 people participated in the research.
h. Organized a 7-day international training on Trauma and Global health in collaboration with Medicine-Tribhuvan University Teaching Hospital (IOM-TUTH) in and Douglas Hospital Research Centre (DHRC), McGill University, Montreal Canada. Where 45 people participated.
i. Provided specialized treatment to 6 people referred by psychosocial workers from different districts at CVICT centre.
j. Midterm evaluation – Outcome mapping questionnaire (See Annex OM Nepal)

Outcome mapping challenges summary

Outcome challenge (a): Developing sustainable partnerships

The partnerships were established basically for technical support, implementation of the certain components of the project and lobbying. (see country report for a detailed description);

Outcome challenge (b): Gaining the trust and recognition of partners (see country report for details);

Outcome challenge (c): Establishing a minimum administrative structure

CVICT established an additional administrative structure in an existing administrative structure for the design, implementation, monitoring and supervision of the Trauma and Global health project. Different activities were planned and implemented in three districts of the country. In this regard, to design and implement some components of the project, CVICT established tacit as well as formal partnerships with Non-Governmental Organizations (NGOs), Governmental Organizations (GOs) and persons related with this field. CVICT prepared a work plan together with partners and divided the roles and responsibilities for the implementation of the project through discussions. CVICT shared relevant and necessary information with its partners like TPO-Nepal, Scientific Committee, Ministry of Health and Nepal Health Research Council among others. The information was used by these organizations for various purposes. CVICT also held regular formal and informal meetings with these organizations and communicated regularly through email and telephone.

Outcome challenge (d): Upgrading research capacity and research skills

To design and implement the activities planned, information was collected from different sources. Information/ articles/ manuals related to conflict/ violence/ disaster & mental

health and psychological/psychosocial interventions used in emergency and post emergency settings were collected and used. Different search engines, McGill Library, TGH web page, HINARI, publications of experts in the field, publications of local organizations etc all are used as the source of information. Collected information was stored in the computer and used and distributed these information as per the need.
In the first year, the research study on the impact of armed conflict related (political) violence on the psychosocial well-being of the community people living in rural areas was planned. This research was designed to be conducted in two phases: qualitative research in first phase and quantitative research in the second phase. The general objectives of the research were: to study the impact of armed conflict on the psychosocial wellbeing of the people in and to identify the resources that people employ to deal with that impact. The Following points have been taken into consideration while setting up the *Research Agendas*:

- Availability of the resources
- Access to the study area
- Geographic location (Hill and Terai)
- Population density and development (Rural and urban)
- Caste/ethnicity (Homogenous or heterogeneous composition of caste/ethnic groups)
- Impact of conflict (Less/moderately/highly affected areas)
- Gender and age group
- Research ethics

Several discussion meetings between scientific committee and CVICT and would be partner organization (TPO-Nepal) were held and the research protocol was developed. For data collection six Field Research Assistants (FRAs) were trained for a month indifferent research methods. The training focused on the research background and research objectives, basics of doing research, qualitative and quantitative research, research ethics, conducting semi-structured interviews (key-informant interviews), conducting focus group discussion, Conducing Participatory Psychosocial Assessment (PPA) and functioning assessment. Basically, the training focused on theory and practice. In each day, the training was divided into two sections. In the first section, the trainers taught field research assistants and in the second section the field research assistants conducted role-play. Similarly, taking informed consent, rapport building, confidentiality and effective communication skill were also addressed in the training.
After the training FRAs went back to respective districts and started collecting data. Both qualitative and quantitative methods have been used for data collection. In qualitative phase, the widely used ethnographic techniques such as 36 Focus Group Discussions (FGDs) and 72 Key Informant Interview (KIIs) were used. Similarly, Participatory Psychosocial Assessment (PPA) was used to explore how community people can be involved in designing and monitoring of the program. In quantitative phase, a structured questionnaire was used. The questionnaire included background information, functioning assessment, anxiety inventory, depression inventory, PTSD symptoms checklist, psychosocial and mental health problem scale, psychosocial stressors and social impact of violence scale, and resources and coping scale.

Purposive sampling method was used for the selection of individual participant in qualitative phase. Mostly, three strategies were used to identify participants: Community meetings, Snowball sampling, Convenience sampling and Proportionate stratified random household sampling method was used for the survey.
Qualitative data collected from different districts by using aforementioned techniques, was transcribed and edited manually. Then it was translated in English and typed in MS Word. Thereafter, data was analyzed for the purpose of developing context specific tools where as thorough analysis of the data is going on.
For quantitative data, 720 all the completed survey questionnaires (N= 720) were manually edited and coded by the field research assistants before entering it into the computer. Statistical Package of Social Science 12.0 (SPSS 12.0) was used to computerize the data. Inconsistencies were eliminated manually before analysis. In addition, quality of data entry was assessed by doing double entry of 20% of randomly selected questionnaires.

Outcome challenge (e): Developing effective and culturally sensitive mental health interventions

Based on the findings of the qualitative research conducted in 2007, national/international literature on political/mass violence and its impact on the psychosocial wellbeing of community people and national/international literature on psychosocial interventions for complex emergencies/ and post-emergencies/war/conflict situations, an intervention model called Community Mental Health Promotion Program (CMHPP) was developed and implemented in the three research districts and the process evaluation of CMHPP was also conducted. For the implementation of CMHPP 12 people from three districts were hired and trained for one month.

Outcome challenge (i): Making acquired knowledge available at various levels

We are in the process of finalizing the analysis of the quantitative data so it hasn't been published or presented in any scientific meetings or disseminated. We plan to present the results to different stakeholders next year (2010). However, the Psychosocial Workers (PSWs) presented the preliminary findings in the communities during the Community Mental Health Programs conducted in 15 Village Development Committees (VDCs) of three districts (Dang, Chitwan and Tanahu) and the Country Team Leader presented in the international course on Trauma and Global Health, a 7-day course, organized by Institute of Medicine-Tribhuvan University Teaching Hospital (IOM-TUTH) in collaboration with Centre for Victims of Torture (CVICT), Nepal and Douglas Hospital Research Centre (DHRC), McGill University, Montreal Canada.

Outcome challenge (j): Promoting gender equality

Outcome challenge (j): Promoting gender equality and gender-based comparative framework.
Efforts were made to maintain gender equality in every aspects of the project. The number of participants in TGH related activities differs each year based on the work plan. In the year one there were 11 male (including Country Team Leader and scientific committee members) and 7 female. In the year two there were 12 male and 8 female in

the program. CVICT recruited 3 male and 3 female field staffs and in year two 6 female and 6 male field staffs were recruited.
Structural/power discrepancies in gender relations:

- Women are assigned those tasks which are not economically productive. Most of the women in communities are supposed to look after cattle and household for which they are not paid. Men are the head of the family and most of the decisions of the family are taken by men. For example in CMHP workshops most of the participants were female and in some workshops there were women only and we asked those women participants why men were not coming for the workshops then they said that you do not give allowance (money) for coming to the workshops that is why they asked us to come for the workshops. Further, they added, they would have come if they were given some allowances. This issue became evident when we analyzed the data of community meeting. In community meetings there were more male participants. In this community meeting people from different organizations and communities were invited. It was when psychosocial workers explained about CMHP (what it is and how it works, what will the participants learn or get by coming to the workshops etc.). From this meeting realized that they will not get any money so they send women.
- Men are leading all formal structure of government, social as well as household (men are influencing in all decisions)
- Men are playing dominating role even in individual and household level.
- Structurally women are not involved in policy making process
- Boys get good care and intention from family members and neighbors during their growing. Girls learn to be powerless from very beginning of their life.
- Sons/boys are considered the generation handover means so they are socialized to be a ruler and power holder. Daughters/girls are involved in decision making process even in household level.

Structural/power discrepancies existed and persisted due to following reasons:

- Mostly elite women are leading gender issues, needy women and girls are marginalized even in women movements
- Half of the total population (Men and boys) aren't taking responsibility to make the gender equitable society. Men are taking gender issues as women/girls issues.
- Discriminatory law and socio-cultural system regarding property rights and marriage. Women have to go to men’s house after marriage and women’s do not have the right on the property of parents after they get married.

Conclusions: future directions and challenges

Trauma and Global Health program is running smoothly as planned and we hope that it will continue in that manner. Our plan for the future is to build the capacity of community people (field workers) in health research and psychosocial/mental health care and to transfer the knowledge we have acquired through research and many years of experience to different stakeholders in Nepal. This means that, existing psychosocial counseling course will be modified based on the research findings and 8 trainees from 3 districts from the pool of Psychosocial Workers (PSWs) will be selected and trained in

psychosocial counseling for four months. Then these trained counselors will go back to respective communities and conduct Community Mental Health Promotion (CMHP) programs, screen people in risk for development of severe psychosocial and mental health problems, provide counseling service and make referral to CVICT and other organizations as appropriate. In parallel with the implementation of CMHP, we will design the research to asses the effectiveness of the intervention by using both qualitative and quantitative measures. Subsequently, we will compile the information and knowledge we have gained and transfer and exchange it with different stakeholders. This transfer and exchange will take place through interaction programs with different levels of stakeholders.

However, the volatile political situation and ongoing agitation violence and frequent shut down strikes, stagnation in development, different interests and priorities of the government and other organizations, rise in the price of commodities will certainly make it more challenging for us in future. Moreover, the recent political developments in the country such Maoists taking the street after resigning from the government, uncertainty about the drafting of new constitution as consensus among major political parties is a must to draft the new constitution on time (The Constituent Assembly has the mandate of drafting a new constitution within two years), ongoing violent activities in 20 districts of Terai region and long-hour of power cuts in the country puts us in the risk.

Midterm-evaluation: SRI LANKA

Context

Since the inception of the Trauma & Global Health (TGH) Programme in Sri Lanka in 2007, the country has experienced an escalation of the war between the Sri Lankan armed forces and the militant organization Liberation Tigers of Tamil Eelam (LTTE). The Sri Lankan armed forces launched a massive operation against the LTTE in mid-2008 which has resulted in driving LTTE militants from the northern region having done so in the eastern region during the previous year. The LTTE cadres are now (May 2009) surrounded by Sri Lankan armed forces and confined to a few square Km in the Mullativu district (Northeast) together with an estimated number of 20-30,000 civilians who were taken by LTTE militants as the latter retreated. The armed forces claim to be engaged in an operation to rescue the civilian population while attacking the remaining LTTE militants.

With this quarter century prolonged war almost coming to an end, the country is faced with a new set of challenges which need to be addressed sooner or later. The war in the north and east has displaced a large population who are now located in the welfare camps. The immediate need is for re-union of families, temporary housing, livelihoods, children's education, health, water and sanitation etc. as well as psycho-social support pending re-settlement of the displaced people in their lands of origin. Additionally, there is a need for de-mining areas which were recently battle fields, reconstructing housing and basic infrastructure which would have been destroyed or damaged during the recent fighting and help in reconstructing community life so that the affected population enjoy basic physical and mental security. The government has already begun the re-settlement process in the eastern region while plans are being made for similar process in the northern region.

Apart from these massive consequences and challenges of the war, populations affected by the 2004 Asian tsunami have not entirely recovered from the effects of that natural disaster. Re-settlement of tsunami-affected people, particularly those in the eastern region has yet to be completed while several material and psycho-social issues in the new re-settlements, such as livelihood restoration, providing necessary infrastructure facilities and psycho-social integration have to be further addressed with adequate support services.

The global economic recession has begun to have a drastic impact on financial institutions, production processes, employment and people's standard of living. As a result, resources available to embark on a major re-settlement, rehabilitation and development process particularly in the conflict affected regions have become scarce. While enormous resources are still drained by the on-going war, the government is severely confronted with the challenge of maintaining a favorable economic climate in the country and to counteract the adverse consequences of the global recession.

In this socio-political context, the TGH programme in Sri Lanka has largely focused its research and capacity building efforts in addressing mental health issues in the

communities affected by conflict and the tsunami, enhancing knowledge and skills of service providers, particularly those engaged in mental health and psychosocial support, and contributing to the policies and practices that aim to improve the overall wellbeing of the affected communities. Though the country's war situation has had no drastic impact on the overall TGH programme, building partnerships with agencies working in the conflict affected north (Jaffna) and researching into the wellbeing of the northern communities could not be accomplished because of security concerns. Furthermore, the research work in the eastern region (Batticaloa) was also frequently disturbed and delayed by the ongoing armed conflict and regular disruptions in the security situation.

Programme Achievements

The period from May 2007 to April 2009 marked significant achievements for the TGH programme in Sri Lanka. They included the following.

a. Networks and partnerships: extended to a range of professional agencies and persons working on mental health and psychosocial issues which included 02 leading government institutions; 03 national NGOs; 03 international NGOs; 01 Network of psychosocial agencies; and 07 professionals (see Annexes SL1-8 & SL33).
b. Research: Adopting participatory methodologies as the key instrument of consultations with community members, an extensive study of two years on the wellbeing of conflict and tsunami affected communities was conducted in five locations covering three districts spread over south, east and north-west of the country (see Annexes SL10 & SL11).
c. Research: 'Community perceptions of mental health and mental illnesses' was another participatory study conducted in two tsunami affected communities in the southern district of Galle (see Annex SL12).
d. Research & capacity building: A 'process-tool-kit' for psychosocial interventions which provides a set of guidelines for practitioners working on community based psychosocial interventions was developed (see Annexes SL 13 & SL28).
e. Research & capacity building: Four action research projects for community mental health promotion were piloted in a tsunami affected community (Mirissa) in the southern district of Matara (see Annex SL29).
f. Surveys: A comprehensive literature survey covering diverse aspects of wellbeing, mental health, treatment and community care was completed (see Annex SL30).
g. Workshops: An international workshop of 6 days divided into three sections (transcultural psychiatry, trauma & global health and qualitative research methods) conducted by resource persons from McGill University and participated altogether by 229 persons was held in January 2008 (see Annex SL9).
h. Workshops: A two-day national workshop on 'wellbeing, mental health and community care' attended by 99 persons was held in March 2009.
i. Grants: A supplementary research grant of US $22,000 from Oxfam America and support funds of SL Rupees 445,500 from the Colombo Office of the WHO for the local expenses of the international workshop were received (see Annexes SL7 & SL31).

j. Publications: One local publication and two international publications based on the outcomes of the wellbeing research (see Annex SL26a & SL27).
k. Information dissemination: Two articles in the Oxfam Newsletter and one article in the AlertNet of Reuters on the process and the outcome of the tsunami wellbeing study were published. Also photocopies and CDs of relevant articles related to mental health were distributed at national & international workshops.
l. Knowledge transfer: Fourteen presentations (based on research outcomes) were delivered by Programme Lead, Project Consultant and programme partners at international & national workshops and conferences and other public forums (see Annexes SL14-SL26 & SL32).
m. Capacity building: Two psychiatrists and two psychologists were awarded fellowships to participate in the McGill summer course on Social & Cultural Psychiatry.
n. Capacity building: More than 15 researchers in social sciences and two trainee psychiatrists received training in participatory research methodologies and its application to studies on mental health and wellbeing.
o. Midterm evaluation – Outcome mapping questionnaire (See Annex OM Sri Lanka)

Outcome mapping challenges summary

Outcome challenge (a): Developing sustainable partnerships

Networks and partnerships established in the project were largely grounded and enriched by interpersonal relationships and informal networks. Also, entering into partnerships was motivated by both personal and common interests of the agreeing parties. While the partnerships were initially activity/event based, they gradually grew up into broader arenas such as mutual sharing, trust and confidence, solidarity and cooperation. There were elements of reciprocity built into the partnerships which facilitated exchange of resources, opportunities for promoting professional career, recognition and image building etc.

Outcome challenge (b): Gaining the trust and recognition of partners

Mutual trust and confidence between partners were maintained and reinforced through regular contacts via telephone and e-mail and in informal meetings. In some cases, partners were accompanied in the process of their individual assignments. Participation in the events organized by the partners and providing technical inputs for the accomplishment of their planned activities helped to strengthen partner trust and confidence which was always reciprocated by partners through information dissemination, joint programme implementation (e.g. National Institute of Mental Health - NIMH), field organization and extending other forms of support, when necessary.

Outcome challenge (c): Establishing a minimum administrative structure

The TGH programme is implemented through a well established local partner, namely PRDA which has extensive experience in project management. The team spirit and the

openness in which the key actors[1] of the project worked and their regular contacts and communication with each other helped the efficient project administration. The advice and technical inputs received from the members of the Core Team and McGill project administration were added assets to project management. The close monitoring and supervision of both the activities and the relationships helped in producing timely outputs. Additional funding that we generated locally helped in extending our research and dissemination work. Working with a variety of actors, particularly with government and international agencies was a novel experience to both the implementing partner and the key actors of the project.

Outcome challenge (d): Upgrading research capacity and research skills

Literature surveys helped to improve the quality and content of the research designs, funding proposals and publications. Relevant articles identified through search engines were disseminated at workshops through CDs, photocopies and emails. The international workshop on transcultural psychiatry was both informative and educative for the participants and it was instrumental in introducing transcultural psychiatry to the Sri Lankan audiences. It also led to a follow-up workshop. The McGill summer course fellowships provided exposure and experience to its participants who in turn started using their new knowledge and experience in their respective fields of teaching, research, networking, treatment and care etc. A number of field researchers in diverse disciplines gained exposure and experience in the application of participatory methods (e.g. participatory rural appraisal) for mental health research. Technical inputs and advice received from McGill team improved quality of our writings, designs and publications.

Outcome challenge (d1): Conducting research

Our research was always guided by the principles of 1) understanding the processes and dynamics of populations affected by conflict and the tsunami from an '*holistic*' perspective; (2) cultural and social sensitivity to the needs of the affected communities/country; (3) relevance to the development of interventions; and (4) participation of the local communities in both research and planning. The research programme adopted a 'bottom-up' approach where partner organizations, advisors, research teams and community representatives were involved in developing research protocols and methodologies, conducting orientations/training, information generation and analysis. In the absence of ethical reviews for social science research, the project developed its own set of ethical guidelines for the conduct of participatory research. The research also facilitated a dialogue with members of the affected communities and created space for them to express their concerns and needs. This entire exercise was also a capacity building exercise for the involved parties and provided a learning opportunity for the partners.

Outcome challenge (i): Making acquired knowledge available at various levels

The project has been successful in mobilizing its partners and research teams to present its research findings at diverse forums such as workshops, conferences, meetings etc. The topics covered in these presentations ranged from issues related to wellbeing of conflict

[1] Refers to Project Consultant, Project Lead and the Executive Director of PRDA.

and tsunami affected communities, community perceptions of mental illnesses, participatory methods as tools for community consultations, best practices of mental health and community care to conceptual/theoretical frameworks of mental health and community care. A little more than 500 people participated in these different forums that included medical professionals, academics and researchers, psychiatric nurses, social workers, counselors, NGO workers, representatives of the government institutions etc. The feedback received was both positive and encouraging. More than anything else, these presentations combined with our local and international publications helped in carrying over the voices of the affected communities to be heard at national and international levels. The research outcomes have also established a solid empirical research base to contribute to the capacity building efforts in the mental health field.

Outcome challenge (j): Promoting gender equality

The project ensured a gender balance in its advisory and administrative structures, research teams, community consultations, workshop participants and beneficiaries of award schemes. Consultations with women in the affected communities were conducted separately to create space for the expression of their independent views and concerns and to avoid possible domination by their counterpart males if mixed groups were consulted particularly in rural settings.

Conclusions: future directions and challenges

a. Promoting community mental health and care in its broader perspective is an enormous challenge in the present context of Sri Lanka where the country is burdened with large refugee populations, their re-settlement and reintegration, rehabilitation and development. Moving away from traditional institution based approaches and practices to mental health and care, reducing dependence on external models and interventions which may be culturally and socially insensitive, building capacities of the service providers to work with communities in providing mental health care and psychosocial support that are socially and culturally appropriate, and preparing them to face the new challenges while mobilizing new resources, are some of the tasks that policy makers and practitioners need to face up to. The TGH programme should endeavor to help at least in some of these fields.
b. Building capacities of the service providers of a diverse spectrum that include medical professionals, administrators, counselors and community/social workers, particularly those working with displaced and re-settled communities need to take precedence over other aims; the TGH programme should focus on enhancing their skills and knowledge in community mental health, conducting community consultations and designing and planning community mental health interventions. For this purpose, appropriate and well-designed capacity building training programmes have to be planned by the TGH programme and implemented through established structures in both the statutory (government) and non-governmental sectors.
c. The TGH programme should aim to strengthen, where possible, local and indigenous institutions such as places of religious worship, traditional healing practices, and community based organizations which are known to provide

valuable services in promoting mental health and have won the trust and confidence of the communities. The programme should interact with these diverse institutions through networking, capacity building and providing resource inputs, and possibly enabling them to develop links with external institutions and knowledge about appropriate interventions. Innovative community based services such as those developed in the Eastern Province could be considered for support and if possible promoting their replication elsewhere.

d. The TGH programme should at all times promote mutual understanding and cooperation among different groups and agencies working in the mental health field avoiding getting involved in competition, rivalries and political agendas, so that it could help in responding effectively to the enormous need in the country, especially among populations affected by conflict and disaster, for mental health and psychosocial support.
e. The TGH programme in Sri Lanka in the next two years (2009-2011), plans to focus its efforts and resources to address these challenges even in a small way and contribute to a growing national need.