CIDA's Policies and Programming in the Area of
Mental Health, 1995 - 2007

by

Melanie McGinnis, B.A.

A Thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Master of Social Work

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*“CIDA’s Policies and Programming in the Area of
Mental Health, 1995-2007”*

Submitted by Melanie McGinnis, B.A. Development Studies

In partial fulfillment of the requirements for
the degree of Master of Social Work

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Abstract

The importance of mental health in the field of international development is gaining the attention of intergovernmental agencies, governments, academics, and non-governmental organizations (NGO's). Using grounded theory and content analysis in NVivo, this study examined the efforts CIDA is making to uphold international standards of human rights as they pertain to mental health and brought attention to the type of mental health interventions being supported by CIDA. This analysis provided an in depth examination of forty seven (47) CIDA project abstracts and one CIDA project approval document. Psychosocial interventions, emerged as the preferred response to mental health issues in conflict/post conflict and post natural disaster situations. It was concluded that social workers are well suited to implement psychosocial programs in international development. Furthermore, the data indicated that CIDA's budget for mental health is relatively low and provides evidence that the value placed on mental health interventions within CIDA is not major.

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TABLE OF CONTENTS

Chapter I: Introduction	1
Importance of Study	2
Research question	4
Organization of thesis	5
 Chapter II: Theoretical Framework	
Introduction	8
Poverty and health in international development	9
Millennium Development Goals	10
Conception of health within CIDA	11
Funding branches in CIDA	15
Theoretical and Clinical treatment in mental health: Current debates	16
From mental illness to mental well being	18
The concept of psychosocial well being and the practice of psychosocial interventions	21
Social work and psychosocial interventions	24
Conclusion	25
 Chapter III: Literature Review	
Introduction	27
Attention given to mental health worldwide and in developing countries	28
Global Burden	29
Social determinants of health	32
Mental and psychosocial disorders as a result of wars and natural disasters	35
Poverty	37
Gender Inequality	39
Models of psychosocial intervention	40
Interagency Standing Committee	41
The World Health Organization	43
The International Federation of Red Cross/Red Crescent Societies	44
The Psychosocial Working Group	46
Health Net - TPO	48
The International Organization for Migration	50
War and post war psychosocial interventions	53
‘Alternative Framework’	54
Conclusion	58
 Chapter IV: Methodology	
Introduction	60
Data Collection Procedures	61
Sample	66
Method of Analysis	68
Grounded Theory	68

Content Analysis.....	71
Methodological Limitations.....	72
Chapter V: Results	
Introduction.....	74
Distribution of project abstracts according to region.....	74
Bar graph No.1.....	75
Amount of funding given to projects addressing conflict/post conflict and natural disasters.....	76
Bar graph No.2.....	77
CIDAs Mental Health Budget.....	77
Chart (Mental Health Budget).....	79
Open coding.....	80
Summary of categories.....	82
Coding for categories.....	85
Coding for nodes.....	87
Queries.....	89
Summary of queries.....	90
Conclusion.....	93
Chapter VI: Analysis	
Introduction.....	94
Analysis by region.....	95
Analysis by budget.....	97
Analysis by type of funding.....	98
Analysis of queries.....	99
Co-occurrence of nodes and sub-region.....	100
Co-occurrence of categories and sub-region.....	102
Co-occurrence of categories and type of funding.....	105
Co-occurrence of categories and nodes.....	108
Co-occurrence of two categories.....	110
Co-occurrence of three categories.....	112
Comparison between abstracts addressing conflict/post conflict and natural disasters.....	113
Conclusion.....	116
Chapter VII: Palestine Project Comparison	
Introduction.....	118
Summary of PAD (Project Approval Document).....	119
Results: CIDA PAD Project (Palestine Project DAP) - Categories.....	122
Results: CIDA PAD Project (Palestine Project DAP) - Categories and nodes....	123
Coding: All Categories and Nodes of Palestine Project PAD.....	124
Summary of project abstracts.....	126
Results: CIDA Project Abstract # A031045and# A031452 - Categories.....	128
Comparison of PAD and project abstracts coding.....	129
Human capacity, social ecology and culture and values nodes.....	131

Conclusion.....	133
Chapter VIII: Conclusion.....	134
Recommendations for further research.....	138
Role of this study in the literature.....	140
List of Appendices	
Appendix A: IASC Matrix of Interventions.....	141
Appendix B: Initial Open Coding Process.....	142
Appendix C: Complete List of Project Abstracts.....	159
Appendix D: Palestine Project Approval Document.....	168
References.....	173

List of Abbreviations

ATIP	Access to Information Program
BHN	Basic Human Needs
CBDP	Community Based Disaster Preparedness
CBFA	Community Based First Aid
CIDA	Canadian International Development Agency
CMHA	Canadian Mental Health Association
DAC	Development Co-operation Directorate
FAO	Food and Agriculture Organization
IASC	Inter Agency Standing Committee
IFRC	International Federation of Red Cross/Red Crescent Societies
IM	Institute of Medicine
IOM	International Organization for Migration
MDG	Millennium Development Goals
OCHA	United Nations Office for Co-ordination of Humanitarian Affairs
PAD	Project Approval Document
PSWG	Psychosocial Working Group
RC/RC	Red Cross/Red Crescent Societies
UN	United Nations
UNDP	UN Development Program
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNPF	UN Population Fund
WFP	World Food Program
WHO	World Health Organization

Chapter I: Introduction

International development interventions often focus on promoting sustainable development and reducing poverty and inequality in the areas of governance, healthcare, gender equality, disaster preparedness, human rights and environment (Canadian International Development Agency [CIDA], 2007a). International development occurs when one country or community provides aid to another country or community. In addition to governments, the aid is provided to non-governmental organizations (NGOs) and multilateral agencies.

Mental health is beginning to be seen as an integral part of overall health and when addressed within the international development framework is generally regarded as a component of health/healthcare. The importance of mental health to the sustainable development of a society has been seen as increasingly significant over the past ten years. This is in part because the global burden of disease¹ associated with mental health is high and is being represented in the literature more frequently. For example, depression is now represented as the fourth leading cause of the global burden of disease and the leading cause of disability worldwide (Worley, 2006; Hyman, 2006; WHO, 2007a).

Over the years, mental health has evolved from the narrow concept of mental illness into a broader concept of mental well being and psychosocial well being. Psychosocial can be described as the consideration of and intersection between the individual and his or her environment (Psychosocial Working Group [PSWG], 2003a;

¹ The Global Burden of Disease uses a summary measure - disability-adjusted life year (DALY) to quantify the burden of disease. The DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health. (WHO, 2007c)

International Federation of Red Cross/Red Crescent Societies [IFRC], 2003). Although scholarly research is limited on the topic, the current research on mental health in international development largely focuses on psychosocial interventions² as being the most operative in conflict/post conflict situations and post natural disasters. Social workers have a role to play in these situations as they use psychosocial interventions to explore and treat the social aspects (which consider the individuals and the environment in which they live) of mental health. My research will investigate what type of mental health projects CIDA (Canadian International Development Agency) funds and whether social workers are well equipped for this type of work.

Importance of study

Mental health has a high prevalence worldwide and the risks of developing mental health issues increase following traumatic events such as conflict or natural disasters. These risks are intensified in developing countries³ where gender inequality and poverty contribute further to the experience of trauma (Patel, 2007). Furthermore, there is often a lack of resources available in developing countries to treat mental health issues as they arise. This is problematic because within the international literature, mental health is a human right. The high prevalence and risk of developing mental health issues, combined with a lack of resources (human and economic) to address mental health in developing countries makes the issue of upholding human rights in these situations even more important.

² Numerous models of psychosocial interventions will be presented in Chapter III: Literature Review

³ For the purposes of clarity, the term 'developed' will be used to describe high income countries and the term 'developing' will be used to describe low- to- middle income countries. The use of these terms is intended to simplify the categories and not imply value judgements.

Over the past half century, human rights have become increasingly important in the international agenda. There are several human rights standards that are applicable to mental health including the *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)*, the *Vienna Declaration (1993)*, and the *Declaration of Caracas (1990)*. On December 13, 2006, UN Secretary General Kofi Annan adopted the *Convention on the Rights of Persons with Disabilities*. This new convention indicated a growing concern for the rights of those with disabilities, arguing for mental and psychological considerations. Rights for the mentally ill are therefore a derivative of the *UN Declaration of Human Rights of 1948* and the subsequent *Convention on the Rights of Persons with Disabilities 2006*.

The objectives of the United Nations (UN) Charter and international agreements state that a fundamental basis for mental health legislation is human rights. “Key rights and principles include equity and non-discrimination, the right to privacy and individual autonomy, freedom from inhuman and degrading treatment” (WHO, 2005a, p.3). To help ensure treatment, many developed countries have implemented mental health legislation to prevent discrimination against persons with mental disorders and other mental health issues. The lack of access to these rights can impact on a person’s ability to obtain adequate care, employment, education and shelter and are essential for protecting autonomy and liberty. The importance of this study is therefore to explore how CIDA is making efforts to uphold these international standards of human rights and will bring attention to the type of mental health interventions being used by CIDA.

CIDA is “Canada’s lead agency for development assistance” (CIDA, 2008). It is therefore important to examine its contributions to developing countries. Furthermore, the

majority of international NGO's based in Canada receive funding from CIDA for programming. CIDA also provides funding to other Canadian Federal Government Departments to undertake international development related activities. In the 2005-2006 fiscal year, Canada's international aid envelope was \$3.7 billion. CIDA received 78% (\$2.78 billion) of this government allocation. It is therefore the major face of international development assistance for Canada.

Research Question

The topic of this thesis is to study mental health in the context of international development and will explore the importance of mental health in the international development agenda of CIDA. The relevance of mental health in CIDA's agenda will be explored in terms of what areas of mental health are funded by CIDA, what proportion of its overall budget is dedicated to health and what proportion of this health budget is dedicated to mental health. As stated in "*CIDA's Action Plan on Health and Nutrition*" (2001), the agency plans to "contribute to the progressive realization of the right of everyone to the highest attainable standards of physical and mental health through its policy and programming work" (p.5). The focus of this research is to study the support CIDA provides to the promotion and treatment of mental health in developing countries and the manner in which its contributions address the goals identified within its mandate. CIDA's approach and commitment to mental health will be analyzed through a sample of funded projects between 1995 and 2007 in the area of mental health.

The primary research question I explore is:

- **How does CIDA contribute to the realization of the “highest attainable standards of mental health” in developing countries through its policies and programming?**
- Some sub-questions that flow from the above are:
 - What areas of mental health are funded by CIDA?
 - What proportion of its overall budget is dedicated to health? What proportion of its health budget is dedicated to mental health?
 - What theoretical perspectives guide its policy and programming in the area of mental health?

Organization of thesis

The remainder of this thesis consists of seven chapters. Chapter II: Theoretical Framework outlines the emergence of mental health as a component within international development. The theoretical framework highlights the relationship between poverty and poor health and the inequities that exist between developing and developed countries. A central theoretical perspective of this thesis is the model of mental wellness that considers the interaction between the person and his or her environment. The psychosocial approach advances this model of mental wellness and several definitions of psychosocial are presented in the theoretical framework. One last piece presented in the theoretical framework is the suitability of social work practitioners to implement psychosocial interventions.

This project reviews a broad body of literature. Chapter III: Literature Review, presents information about the prevalence of mental illness worldwide and the primary

social determinants of mental health. Risk factors such as poverty and gender inequality that increase the likelihood of psychosocial distress in conflict/post conflict and post natural disaster situations are outlined. The literature review also presents different perspectives of organizations working in the area of international mental health during conflict/post conflict and post natural disaster situations. These organizations include: the Interagency Standing Committee (IASC), the World Health Organization (WHO), the International Federation of Red Cross/Red Crescent (IFRC), the Psychosocial Working Group (PSWG), HealthNet - TPO (Transcultural Psychosocial Organization) and the International Organization for Migration (IOM).

In order to address my research question, as indicated in my methodology section (Chapter IV), I analyzed a total of forty seven project (47) CIDA project abstracts, twenty three (23) of which addressed post natural disaster situations, and twenty four (24) of which addressed conflict/post conflict situations. I also analyzed one PAD (Project Approval Document). I used grounded theory⁴ and content analysis⁵ to conduct the analysis. Every grounded theory and content analysis must begin with a hypothesis.

My hypothesis is that the international development policies and programming of CIDA will be informed by the current international policy framework that addresses mental health issues⁶ through a psychosocial theoretical perspective.

⁴ Grounded theory is a theory that is developed inductively from a corpus of data (Borgatti, 2001). Theories emerge through links between categories, or about a core category which appears central to the study. As the categories and properties emerge, they and their links to the core categories provide the theory (Glaser & Strauss, 1967). More about this later, see Chapter IV: Methodology.

⁵ Ole Holsti (1969) offered a broad definition of content analysis as "any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (p. 14). Researchers quantify and analyze the presence, meanings and relationships of words and concepts, then make inferences about the messages in the texts (Weber, 1990). More about this later, see Chapter IV: Methodology.

⁶ Mental health issues can address many areas, from enhancing emotional well-being, treating and preventing severe mental illness to the prevention of suicide. The goal is to have individuals play an active

Chapter V: Results, presents the results of the queries done in NVivo while Chapter VI: Analysis provides an in depth analysis of the results. The next chapter (Chapter VII) addresses the results of the coding of two project abstracts and an analysis of one PAD. I then compared the findings of the coding of the project abstracts to the findings of the coding of the PAD. The conclusion (Chapter VIII) provides an overview of the study and highlights the importance of this study to the field of social work.

Chapter II: Theoretical framework

Introduction

Until the publication of *The Global Burden of Disease (1996)*, *World Mental Health: problems and priorities in low income countries (1995)* and the WHO *World Health Report of 2001*, mental health was largely ignored in the field of international development. The adoption in 2000 of the Millennium Development Goals into CIDA's mandate and the advancement of international human rights standards has influenced the direction of CIDA's health strategies in recent years. Mental health was mentioned by CIDA as an important component of health programming for the first time in 2001 in *The Action Plan on Health and Nutrition*. The theoretical component of this thesis highlights the relationship between poverty and poor health.

The concept of mental health is central to this thesis and it is therefore important to understand the evolution of the field of mental health. As part of understanding the concept of mental health as a historically constructed category, it is necessary to address the appearance of effective drugs to treat mental illness in the 1950s and 1960s resulting in the emergence of biomedical psychiatry.⁷ This new psychiatry is the most recent in a long series of efforts to fully integrate psychiatry into medicine and has moved psychiatry away from its nineteenth century role of custodial administration of deviance. The exclusively pharmacological approach to mental illness during the second half of the twentieth century in North America has given rise to biomedical reformers who acknowledge that for most mental illnesses, psychotherapy of some sort is necessary (Lakoff, 2005). In the last decade, many studies have indicated that the most effective

⁷ Biomedical psychiatry is an approach in psychiatry that aims to understand mental illness in terms of the biological function of the nervous system but also considers socio-cultural influences on mental illness.

approach to mental illness is a combination of pharmacotherapy and psychotherapy (Madger, Gilbert & Kennedy, 1998; Cameron, P., Ennis, J. & Deadman, J, 1998; Beitman, B., Blinder, B., Thase, M., Riba, M. & Safer, D., 2003; Hollon, S. & Fawcett, J., 1995; Klerman, G., 1991). Combined treatments are often psychosocial in nature and attempt to address the individual within his or her environment; which means they root subjectivity in the social. In this perspective, the quality of the environment is considered to be of critical importance in the creation of a sense of well- being.

Mental health practitioners and mental health policy makers have shifted over the years from an understanding of mental health as the absence of mental illness to an understanding of mental health as a positive sense of mental well being. The concepts of psychosocial well-being and psychosocial interventions address the complex interaction between the individual and his or her environment. A model of mental wellness that considers the interaction between the individual and the environment when applying mental health interventions will constitute the central piece of this thesis's theoretical perspective. The last section discussed in this theoretical framework is the suitability of social work practitioners to implement psychosocial interventions.

Poverty and health in international development

The conditions in which people grow, live, work and age have powerful influences on their health. Scholars rarely disagree that the lower the socioeconomic position, the worse the health of the population. Social and economic conditions effect people's lives and determine their risk of illness within the population. The actions taken to prevent or treat illness and poor health when they occur are also influenced by the social and

economic conditions (WHO, 2006, p.8). Poverty in developing countries contributes to a lack of improvement in health problems which is then exacerbated greatly by the lack of human resources to address these issues. This creates inequities in health between developed and developing countries. These inequities can be demonstrated by life expectancy. The life expectancy in developed countries rose from 71.6 to 78.8 years between 1970- 1975 and 2000-05, while in Sub Saharan Africa (developing countries), the life expectancy rose by only four months from 45.8 to 46.1 in the same period of time (WHO, 2005a).

Millennium Development Goals (MDG)

The Millennium Development goals were adopted in September 2000 when 191 countries adopted the United Nations Millennium Declarations. The MDGs target the areas that were seen to be the most important in the field of international development; these include poverty reduction, health, education, gender equality, environmental sustainability, and global partnerships, all to be reached by 2015. There are eight MDGs⁸ and three of these eight goals relate directly to health (to reduce child mortality, to improve maternal health and to combat HIV/AIDS, malaria and other diseases) and health is a factor in several of the other goals (Patel, 2005).

The MDGs “form a blueprint agreed to by all the world’s countries and all the world’s leading development institutions” (United Nations [UN], 2007). In 2001, CIDA adopted the MDGs as a section of its mandate; “to deliver visible, durable impact on the

⁸ The eight Millennium Development goals are: to eradicate extreme poverty and hunger, to achieve universal primary education, to promote gender equality and empower women, to reduce child mortality, to improve maternal health, to combat HIV/AIDS, malaria and other diseases, to ensure environmental sustainability, and to develop a global partnership for development (UN, 2007c).

world's key development challenges as identified in the MDGs" (CIDA, 2006). The goal of the MDGs is to meet the demands of the world's poorest. As health is intertwined within these goals, health and mental health received attention in *CIDA's Action Plan on Health and Nutrition* for the first time in 2001, as a way to achieve sustainable development and therefore reduce poverty and inequity around the world.

Conception of health within CIDA

Many years had to pass before the concept of mental health was made part of CIDA's mandate. Health became a component that was considered by CIDA after the development of the Basic Human Needs (BHN) by the World Bank in 1973. Numerous developments in the field of general health have occurred within CIDA policies and programming since 1973. As health is a central component of the MDGs, the establishment and adoption of the MDGs by CIDA in 2000 has also contributed to the direction of health programming since that time.

In 1973, the World Bank sponsored a major study called *The Redistribution of Growth*, out of which arose the concept of Basic Human Needs (BHN). The study emphasized tapping new growth to raise productivity of the poor. BHNs were defined as: productive employment, adequate nutrition, clean drinking water, shelter, primary health care and basic education (Morrison, 1998). Addressing BHNs became an integral component of CIDA's mandate and ensured that primary health care became part of the agency's agenda.

In September 1975, health was incorporated into CIDA's mandate in the *Strategy for International Development Co-operation 1975-1980*. Point 7 of the strategy conveyed

determination “to focus aid more sharply on sectoral priorities that would address basic needs- food production and distribution, rural development, health, population and housing-without dropping any of the existing ones” (Morrison, 1998, p.117).

Unfortunately, at this point Canada’s performance lagged well behind the average statistics recorded in the Development Co-operation Directorate (DAC) compared to other DAC members in all social spheres, especially health and education. In 1975, while the average of all DAC contributions by member countries to health as a percentage of all aid expenditures was 9.3 percent, Canada’s was 4.1 percent. The situation became worse in 1976 when the percentages given to health were 10.3 and 2.5 respectively.

In December 1977, the strategy *Directions for the Agency: From Now Until the 1980’s* was established. During this time, the pursuit of commercial and political interests dominated policy and programming development (Morrison, 1998). The new liberal government of the time, headed by Prime Minister Trudeau, established The Parliamentary Task Force on North South Relations to “examine the relationships between developed and developing countries in the areas of food, energy, trade, balance of payments” (Morrison, 1998, p. 179) as well as assistance to the most poor. The task force praised non- governmental organization’s (NGOs) and their efforts to meet the human needs of the poorest. The report recommended increasing funding to NGOs for small bilateral projects in agriculture, health and rural development (Morrison, 1998). CIDA responded to the recommendations of the task force by a genuine attempt to increase North-South partnerships, including partnerships that promoted health.

In 1996, CIDA published its *Strategy for Health*. *The Strategy for Health* was set in the framework of the program priorities outlined in *Canada in the World (1995)*. CIDA

published *Canada in the World (1995)* as a five year investment plan that included an increase in spending in the areas of; health and nutrition, basic education, HIV/AIDS, and child protection. Within this document, one of the objectives is to, “help prevent and control important and emerging pandemics which cause more than 1 million deaths per year and for which cost-effective interventions exist” (CIDA, 1995). While health became a part of CIDA's mandate following the development of the BHNs by the World Bank in 1973, the first mention of a field that is related to mental health in a CIDA document did not emerge until the publication of the *Strategy for Health* in 1996, fifteen years following the *Strategy for International Development Co operation 1975-1980* and *Directions for the Agency: From Now Until the 1980's*.

CIDA's Action Plan on Health and Nutrition was published in 2001 and was built on the *Strategy for Health*. It was also developed in response to the goals indicated by the MDGs to reduce poverty by 50 percent by 2015. The document stated that it would be necessary to identify and address the obstacles that limit the ability to obtain the highest attainable standard of physical and mental health (CIDA, 2001). Mental health is mentioned as integral to programs targeting family planning and safe motherhood. Expanding upon the inclusion of mental health in the *Strategy for Health (1996)* and for the first time in CIDA's history, *CIDA's Action Plan on Health and Nutrition (2001)* recognizes that mental health issues are among the most important contributors to the global burden of disease and disability (CIDA, 2001).

Furthermore, mental health is stated as an important characteristic of the integrated, multi-sectoral approach. In preventing and controlling non-communicable diseases, “CIDA will encourage programs which primarily address prevention, care and

mental health disorders among women, children and youth” (CIDA, 2001, p.48). CIDA’s Action Plan states that in terms of mental health, it will concentrate on programs that protect children from mental disorders as well as increasing the competency of mental health care workers. Once health became a priority on the international agenda in the early 1970s, CIDA’s attention to health grew progressively until the eventual inclusion of the importance of mental health to overall health. The policy transformations that occurred over the years paved the way for the concept of mental health to be incorporated into CIDA’s mandate.

Historically, mental health has been largely ignored by international development agencies worldwide. The inclusion of mental health within CIDA’s health strategy coincides with three important documents that raised the awareness of the importance of mental health in development worldwide. The first book to broaden the scope of mental disorders beyond the biomedical boundaries to include larger social determinants and consequences of mental illness was *World Mental Health: problems and priorities in low income countries* (1995) written by Desjarlais, Eiesenburg and Kleinman (1995). The second influential document was *The Global Burden of Disease* (1996), written jointly by the WHO and the World Bank; it expanded the scope of the global burden of disease to include disability. The document established mental disorders as a clear element of disability and therefore an important element to consider. The third and perhaps most influential document was the WHO *World Health Report of 2001*. This report ensured that mental health was the focus for that year. As a result, many developing countries received more funding for mental health initiatives. These three documents clearly identified mental health as a key element of health, resulting in a growing concern for mental health

issues by the international community. Academic research also continues to support the importance of addressing mental health issues within the sphere of international development.

Funding branches in CIDA

There are three different branches of CIDA that provide funding for projects, including those that contain a component of mental health. The first is the multilateral branch. Multilateral organizations “help set the rules for the governance of the world economy and in areas such as health, agriculture, human rights, peace and security and humanitarian assistance” (CIDA, 2007b). For example, they set international objectives such as the Millenium Development Goals. The term ‘multilateral’ stems from the fact that they are supported financially by many countries. Such organizations include international financial institutions such as the World Bank, The International Monetary Fund, regional development banks, the UN Development Organizations, Global funds and partnerships, Commonwealth, La Francophonie and humanitarian assistance organizations such as the Red Cross International. Money provided by CIDA from the multilateral branch is given to any number of these multilateral agencies.

CIDA also provides funding to health projects through the bilateral branch. Bilateral aid is given directly from one government to another government in need of assistance. Examples of aid agencies are USAID (United States), Department for International Development (DFID, United Kingdom), and Swedish International Development Agency (SIDA). CIDA itself is an example of a bilateral aid agency. Under the Mulroney government bilateral aid flows for CIDA varied between \$900 million to

\$1,100 million in constant U.S. dollars (1995). During the Chretien government bilateral aid declined remarkably and by the year 2000, bilateral aid was \$489 million (excluding aid to Poland as it was a middle income country). This represents “52% of their level in 1984” (Macdonald & Hoddinott, 2004, p.300). Money provided by the bilateral branch of CIDA is given directly to governments to implement specific programs.

The third section of CIDA that provides funding is the partnership branch. The partnership branch encourages Canadian private and voluntary sector organizations such as “non-governmental organizations, educational institutions, professional memberships and associations, cooperatives, youth organizations, and companies” (CIDA, 2007c) to contribute to international cooperation initiatives. When CIDA provides money for projects through the partnership branch, the funded organizations then implement the specified programs.

Theoretical and Clinical treatment in mental health: Current debates

The arrival of the new biomedical psychiatry has been either celebrated as the result of scientific discovery or criticized as a disturbing form of social control linked to a loss of personal autonomy and responsibility (Fukuyama, 2002; Kramer, 1993; Valenstein, 1998). There is ongoing debate over the definition of psychiatry’s validity as a result of its focus on the “psyche” or “soul” in secular modernity (Hacking, 1998). As “effective” drugs to treat mental illness began to appear in the developed world during the 1950s and 1960s, illness became gradually defined in terms of that to which it “responds”. In the 1950s, chlorpromazine (Thorazine) was discovered as capable of altering mood and mental states. Patients experiencing mental illness were calmer and less problematic

for caregivers (Valenstein, 1998). Before the discovery of chlorpromazine, mental illness was treated with intense psychotherapy that was expensive and time consuming. Since chlorpromazine was seen to be more cost effective, it therefore became widely accepted. It was also endorsed by several influential psychiatrists of the time (Valenstein, 1998).

In 1957, psychiatrist Paul Janssen accidentally discovered another class of antipsychotic drugs to be called haloperidol (Haldol). Haloperidol caused the serious side effect of motor impairment but at the time, the benefits of reducing psychotic symptoms were thought to outweigh this serious side-effect. Other drugs such as iproniazid and other tricyclic anti-depressants were also 'discovered' around this time. In the late 1950s, lithium was seen as one of the most effective treatments for mania and other mood disorders. Furthermore, "anti-anxiety (anxiolytic) drugs such as Valium, Librium, Xanax and Ativan all became widely used in the 1960's" (Valenstein, 1998, p.160). Because of the discovery of drugs that were capable of altering mood and mental states, between 1950 and 1960 psychiatry in North America went from blaming the presence of mental disorders on early experiences with the family to blaming chemical imbalances in the brain (Valenstein, 1998). However, pharmacotherapy is increasingly alarming researchers and practitioners in the field of psychiatry and psychology due to their long lasting, complex side-effects.

Currently, combined treatment is preferred by a large proportion of mental health professionals (Beitman et al, 2003 & Valenstein, 1998). However, lack of time and money diminish opportunities for professional training. Combined treatment is best established for schizophrenia; severe, recurrent or chronic major depressive disorders; obsessive compulsive disorder; depression and (more recently) bipolar disorder. Although results

are less consistent, benefits have also been demonstrated for bulimia and panic disorder (Beitman et al, 2003). Pharmacotherapy can provide reliable reductions in symptoms and suppress relapse or recurrence and psychotherapy can enhance social functioning and reduce risk of recurrent episodes (Hollon & Fawcett, 1995). Nevertheless, the long term side effects of pharmacotherapy are preoccupying researchers in the field of psychiatry. Combined with pharmacotherapy, psychotherapy is viewed as being effective for lessening psychosocial dysfunction and helping patients to cope with stress-related emotions.

From mental illness to mental health

Over the years, mental health has been an unstable category and as a result numerous debates have emerged in response to different mental health theoretical perspectives. Prior to the middle of this century, the absence of mental illness was considered indicative of a positive sense of subjective well being (Greenspoon, P. & Saklofske, D., 2001). This was most likely due to psychology's roots within the medical model of health and illness. Since then, the field of mental health has evolved from an understanding of mental well being as the absence of mental illness to an understanding of mental well being that is not solely the absence of mental illness but also a positive sense of subjective well being.

A subjective standpoint to well being is the evaluation that an individual makes about the quality of his/her life (Diener, E., Lucas, R., Oishi, S. & Suh, E., 1999; Keyes et al. 2002).⁹ In the 1950's, the subjective standpoint emerged as an alternative to the

⁹ Six dimensions of well-being according to Ryff and Keyes (1995) are: positive evaluation of oneself and one's past life, a sense of continued growth and development as a person, the belief that one's life is

objective approach used to measure an individual's well-being (Keyes, 2006). After the physical, psychological, social and moral devastation of World War II, there was a newfound commitment to social welfare, particularly in the fields of philosophy, sociology, and psychology where scholars were concerning themselves with the importance of personal meaning and concerns about modern life. The subjective well being approach to mental health therefore emerged as a scientific field in the late 1950s when social scientists developed indicators for quality of life to monitor social change (Keyes, 2006).

In 1958, Marie Jahoda's publication on positive mental health stated that a variety of concepts from personality, developmental, and clinical psychology had "been synthesized as criteria of mental health and psychosocial well-being" (Keyes, p.4, 2006). In this seminal publication Jahoda argued that "it is unlikely that the concept of mental health can be usefully defined by identifying it with the absence of disease" (Keyes, 2006, p.4) and went on to say that although the absence of disease may be a necessary component in maintaining good mental health, it does not ensure the mental health of a person (Greenspoon, P. & Saklofske, D, 2001). The ideas presented by Jahoda (1958) are central to a more psychosocial view to mental health and were key to the development of the concept of subjective well being.

Researchers and theorists have been advocating for the importance of subjective well being in the understanding of mental health for the last half century (Greenspoon, P. & Saklofske, D., 2005). According to *The Mental Health of Canadians: Striking a Balance* (1989), mental health is defined as:

purposeful and meaningful, the possession of quality relations with others, the capacity to manage effectively one's life and surrounding world, and a sense of self-determination.

the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality (p.7).

The World Health Organization (WHO), which is the largest international organization focused on health, defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2001a, p.1).¹⁰ The Canadian Mental Health Association (CMHA) also emphasizes mental health as not merely an absence of disease. It currently defines mental health in the following way:

Today, we recognize that good mental health is not just the absence of mental illness. Nor is it absolute – some people are more mentally healthy than others, whether you are mentally ill or not. These realizations are prompting a new kind of focus on mental health that identifies components of mental wellness and mental fitness and explore ways to encourage them. (CMHA 2006)

Mental wellness is defined by Jones and Kilpatrick (1996) as "a state of harmony, energy, positive productivity and well being in an individuals' mind, body, emotions and spirit" (p.259). The wellness theory includes the biological, psychological, social and spiritual aspects of the functioning of the person-in-environment. The wellness model emphasises not only the relationship between an individual and his/her family and other interpersonal connections but also the relationship between the person and his/her physical environment, community and larger society (Jones & Kilpatrick, 1996). The change in focus in the field of mental health to aspects of mental wellness is best

¹⁰ Mental disorders are understood by the World Health Organization (WHO) as, "clinically *significant conditions characterized by alterations in thinking, mood (emotions) or behavior* associated with personal distress and/or impaired functioning. Mental and behavioural disorders are not just variations within the range of 'normal', but are clearly abnormal or pathological phenomena." (WHO, 2001, p. 21). This understanding is disputed by a number of psychiatrists, particularly those following the British tradition of social psychiatry and continental psychoanalysis. However, this debate is beyond the scope of this thesis.

addressed by the concept of psychosocial well being and psychosocial interventions, and runs parallel and contemporaneous to the biological psychiatry approach to mental health.

The concept of psychosocial well being and the practice of psychosocial interventions

Psychosocial is acknowledged as the intersection between individual emotional reactions (psycho) and the relations between people (social) (IFRC, 2004). The concepts of psychosocial well being and psychosocial interventions are built upon this notion of psychosocial. The Psychosocial Working Group (PSWG), which is a collection of academic institutions and humanitarian agencies jointly co-ordinated by Queen Margaret University College, Institute of International Health Development in Edinburgh and the University of Oxford, Refugee Studies Centre in Oxford, supports a broad definition of psychosocial. According to this group the term psychosocial is used to emphasize the close connection between our psychological experiences (our thoughts, emotions and behaviour) and our social experiences (our relationships, traditions and culture) (PSWG, 2003b, p.1). The psychosocial approach emphasizes this connection to achieve well being which ensures that the family and community are recognized as important aspects in mental health (PSWG, 2003c). Psychosocial well being therefore involves human capacity (includes the physical and mental health of a person as well as his or her knowledge and skills), social ecology (refers to the social connections and support that people share and that form an important part of psychosocial well being) and culture and values (point to the specific context and culture of communities that influence how people experience, understand and respond to events) (PSWG, 2003b).

Psychosocial well being can be achieved through psychosocial interventions. The Interagency Standing Committee (IASC) uses the composite term, 'mental health and psychosocial support' to describe any outside interventions that protect or promote the psychosocial well being or treatment of mental illness of an affected population (IASC, 2007). The WHO also believes that good mental health interventions and good psychosocial interventions are the same and proposes to avoid focusing on conceptual distinctions between them. The term therefore used by WHO is also 'mental health and psychosocial support'. This term includes interventions that lead to social effects as well as clinical interventions (medication, psychotherapy) and basic, non-clinical, psychological support (WHO, 2005c). The definition of psychosocial interventions supported by the International Federation of Red Cross/Red Crescent Societies is "... a process of facilitating resilience within individuals, families, and communities. Through respecting individuals' and communities' independence, dignity and coping mechanisms, psychosocial support promotes the restoration of social cohesion and infrastructure" (IFRC, 2003).

Psychosocial interventions can also be defined in numerous ways that include consideration of the socio-political context. HealthNet- TPO (Transcultural Psychosocial Organization) promotes a public mental health perspective as the most viable and useful model of psychosocial intervention in developing countries. The idea is to reconnect individuals with their ordinary support systems to cope with initial trauma. They suggest that interventions should consider the sociopolitical context and assist with immediate crisis response but also strengthen communities, families and individuals and provide them with sustainable options for self help in the future (de Jong, 2002). The International

Organization for Migration (IOM) also takes into consideration the sociopolitical context. They believe that psychosocial interventions should be "...an attempt to overcome traditional (individualistic, psychological and PTSD oriented) methods of assessing and dealing with the problem of trauma, and to reconsider it within its sociopolitical context" (Losi, 2000, p.16).

Agger, a psychologist associated with the Institute of Cultural Sociology, University of Copenhagen and the OASIS Treatment and Counseling Centre for Refugees, Copenhagen, Denmark is an author often cited in the international psychosocial literature and defines 'psychosocial' in war and post war situations differently. According to Agger (2001), "The aim of psycho-social emergency assistance under war conditions is to promote mental health and human rights by strategies that support the already existing protective social and psychological factors and diminish stressor factors at different levels of intervention" (p.248). Agger (2001) defines 'psychosocial' under post-war conditions differently than during times of war. Under post-war conditions, psychosocial interventions are defined as the promotion of "mental health and human rights by therapeutic strategies that promote dialogue, confidence building, and reconciliation, and diminish ethnic tensions at different levels of intervention" (Agger, 2001, p.249). Lykes and Mersky (2006) support a psychosocial orientation to reparations programming addressing war, post-war and transitional situations that are shaped by individuals, families and groups in their neighborhoods, their communities, their towns, cities and their societies. Furthermore, the authors believe that psychosocial reparations work should be integrated and enacted within specific historical, cultural and sociopolitical contexts.

Although the psychosocial definitions presented in this section focus on different aspects of psychosocial interventions, they all consider the individual in his or her social environment, which is the core concept of psychosocial well being.

Social work and psychosocial interventions

Social workers are the best suited to deliver psychosocial interventions. A central role of social work within the area of mental health is to “restore individual, family, and community well being, to promote the development of each individual’s power and control over their lives, and to promote principles of social justice” (Bland, R. & Renouf, N., 2001, p.238). Other disciplines may recognize the importance of working with families and caregivers of those who are mentally ill but the strength that social work brings to the field of mental health is that they are also concerned with the impact of mental health concerns on family relationships and roles. Furthermore, social workers in the area of mental health are concerned with the impact of mental ill health on the broader community (Bland, R. & Renouf, N., 2001). Psychosocial caseworkers, who are often referred to as clinical social workers, seek to aid individuals, families and larger groups to reduce some type of disequilibrium between them and their environments (Woods & Robinson, 1996). The focus of social work within mental health is therefore inherently psychosocial.

Furthermore, social work has the capacity to link the experience of mental health with broader personal and societal concerns which is highly applicable to the field of international development. Hokenstad and Midgley (1997) argue that social workers should adopt a developmental approach to international social work. This perspective

seeks to promote the well-being of people through harmonizing economic and social policies in the development process (Hokenstad, M.C., & Midgley, J, 1997, p.15). It promotes a change-oriented process that is inclusive and universalistic, and seeks to enhance peoples' welfare by integrating the economic and social dimensions of development (Hokenstad, M.C., & Midgley, J., 1997). The link between social work and international development is therefore apparent because social work is traditionally concerned with disadvantage and social justice and has a long history of working with deprived and needy populations, having a global involvement and an ethical commitment to promoting human well-being (Hokenstad, M.C., & Midgley, J., 1997). As the interest in mental health in international development continues to grow, the need for trained individuals to carry out psychosocial interventions will increase. Social workers therefore have a potentially large role to play in the area of mental health in international development.

Conclusion

There is a clear link between health and poverty where those in developed countries experience better health than those in developing countries. In 2001, after CIDA's adoption of the MDGs into its mandate, mental health became an objective in CIDA's health mandate. The international community at large is also beginning to address the importance of mental health to international development. The analysis of the data collected for this thesis will determine the relative importance of mental health in CIDA's mandate and its relation to its overall budget as well as its health budget.

Although, during the 1950s and 1960s, drugs became an effective treatment for mental illness, most mental health experts currently endorse a combined treatment method that offers patients a comprehensive care system. The ongoing debate over how to best promote mental health in Western countries is likely contributing to the lack of relative clarity of the concept of mental health in international development. The confusion over the most effective treatment methods in Western countries could have complicated the ability of aid agencies to determine the best course of action in developing countries. Eventually, a focus on psychosocial support in post conflict and natural disasters seems to have been adopted. Social workers are a natural fit to perform these psychosocial interventions. The analysis of the data collected for this thesis will be informed by the theoretical framework described above which provides a dual lens by focusing both on the psychic and social reality of the individual. This social reality differs greatly between developed and developing countries and should always be considered when applying psychosocial interventions.

Chapter III: Literature review

Introduction

Various types of mental health issues exist in most parts of the world, yet mental health has not received the same recognition and attention as other components of health and well-being. Mental health budgets represent a very small percentage of overall government health budgets worldwide. There is also a shortage of mental health human resources, both human and economic particularly in developing countries. Although the literature (WHO, 2001a; IOM, 2003; WB, 2004) demonstrates that it is an important issue, mental health interventions within international development are a relatively new occurrence.

This literature review presents information pertaining to the global burden of disease associated with mental health. A primary social determinant of mental health in developing countries is mental and psychosocial distress as a result of conflict and natural disasters. Additionally, the experiences of poverty and gender inequality increase the risk of developing mental health issues following conflicts or natural disasters. Social work has a role to play in the field of mental health on account of its focus on psychosocial interventions. This review will focus on psychosocial interventions in the field of international mental health during and after conflict and natural disasters. Models of intervention created by the Interagency Standing Committee (IASC), the World Health Organization (WHO), the International Federation of Red Cross/Red Crescent Societies (IFRC), the Psychosocial Working Group (PSWG), HealthNet – TPO, and the International Organization for Migration (IOM) will be outlined. Authors who address

war and post war psychosocial interventions and an 'alternative' framework in the area of reparations will also be presented.

Attention given to mental health worldwide and in developing countries

Historically, the mental health of a population has not been included on the international agenda, which has resulted in a lack of attention given to mental health issues in developing countries. As indicated in the worldwide study conducted by the WHO entitled, "*The Mental Health Atlas 2005*", 28% of countries report not having a specified budget for mental health. Where budgets do exist, they represent only a small proportion of the total health budget. "Of the countries that provided information, 36% of countries reported spending less than 1% of the total health budget on mental health" (WHO, 2001b, p.7). To offer a comparison, 70% of countries in the Africa region (developing countries) spend less than 1% of their health budget on mental health and more than 61.5% of countries in Europe region (composed primarily of developed countries) spend more than 5% of their health budget on mental health (WHO, 2005a).

There is also a marked lack of human resources in the area of mental health, especially in developing countries. There is only one psychiatrist and one psychiatric nurse per 100 000 population in 53% and 46% respectively of the responding countries (WHO, 2001b). This lack of human resources is particularly evident in regions in Africa, South East Asia, Western Pacific and Eastern Mediterranean. Many countries in these regions are considered to be 'developing'. The numbers of psychologists and social workers engaged in mental health is also low with median numbers 0.4 and 0.3 per 100 000 population respectively for these professionals among all countries. This lack of

social workers is especially detrimental to the possible availability of psychosocial interventions as social workers often focus on the social aspect of mental health issues. Attending to the social determinants of mental health and the development of psychosocial interventions is a preferred response to mental health in the field of social work. Although data is not available for social workers, a comparison to Canadian figures where there are 12 psychiatrists per 100 000, 35 psychologists per 100 000, and 44 psychiatric nurses per 100 000 working in mental health highlights the lack of resources available in 'developing' countries (WHO, 2005b).

Global Burden

The lack of resources given to mental health means that the global burden of disease associated with mental health issues is high and that more attention should be paid to this area of health. A report written by the World Health Organization (WHO) in 2003 entitled "*Noncommunicable Diseases, Mental Health and Injuries*" estimated that in 2020, the breakdown of the Global Burden of Disease will be as follows: 22% communicable diseases, 43% non-communicable diseases, 14% neuropsychiatric disorders, 21% injuries (WHO, 2003a). Others have more recently ranked depression as the fourth leading cause of the global burden of disease and the leading cause of disability worldwide (Worley, 2006; Hyman, 2006).

YLDs (years lived with a disability that people experience in their lifetime) and DALYs (the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability) are both common measurements of disability (WHO, 2007a). According to WHO's global burden of disease 2001 report, 33% of years lived

with disability (YLD) worldwide are due to neuropsychiatric disorders, a further 2.1% to intentional injuries such as suicide. Unipolar depressive disorders alone lead to 12.15% of years lived with disability, and rank as the third leading contributor to the global burden of diseases (WHO, 2003a, p.8). “Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder)” (WHO, 2003b, p.8).

In developing countries, brain disorders are responsible for at least 27 percent of all years lived with disability (YLDs). In the year 2000, years of life lived with a mental disability as a proportion of all YLDs were: “Africa: 18%, The Americas: 43%, Eastern Mediterranean: 27%, South East Asia: 27%” (WHO, 2001b, p.26). These figures represent the leading contributors to YLDs in the world, with the exception of Africa.

In 1998, The Institute of Medicine (IM) estimated that the percentage of DALYs attributable to brain disorders worldwide was 34%. In developing regions in 1998, unipolar depression was the 4th leading cause of the total percentage of DALYs and self inflicted injuries was 19th. In 2006, unipolar depressive disorder accounted for 3.1% of the total burden of disease in developing countries, making it the leading neuropsychiatric cause of burden of disease (Lopez, Mathers, Ezzari, Jamison & Murray, 2006). The high prevalence of depression and self inflicted injuries of the total percentage of DALY's is of particular concern because, as previously stated, 28% of countries worldwide do not have a specified budget for mental health and 36% of countries spend less than 1% of the total health budget on mental health (WHO, 2001). The likely outcome is that large numbers of people in developing countries are therefore not receiving the mental health services needed.

Besides the burden of disease in terms of years of life there is also a large economic burden associated with mental ill-health. “Indirect costs arising from productivity loss account for a larger proportion of overall costs than direct costs. Furthermore, low treatment costs (because of lack of treatment) may actually increase the indirect costs by increasing the duration of untreated disorders and associated disability (WHO, 2001a; Institute of Medicine [IM], 2001). Caretakers often bear the economic cost of the dependent family member (IM, 2001; WHO, 2001a; WHO, 2003b). Estimates of costs are not available for all the various disorders for most of the countries in the world but estimates from Canada present a clear picture of the cost in the developed world. “The estimated total burden of mental health problems in Canada for 1998 was at least Can \$ 14.4 billion: Can \$8 billion in lost productivity and Can \$6.3 for treatments” (WHO, 2003a, p.15).

“Though the burden of illness resulting from psychiatric and behavioral disorders is enormous, it is grossly underrepresented by conventional public health statistics, which have tended to focus on mortality rather than morbidity or dysfunction” (Desjarlais, et. al. 1995, p.4-5). For example, even when a suicide represents a death due to depression or schizophrenia or drug addiction, it is tabulated as suicide (Desjarlais et al., 1995). Furthermore, symptoms of anxiety and depression are often not recognized (Worley, 2006).

Much of the literature pertaining to the prevalence and burden of mental health in international development is produced by the World Health Organization¹¹, World Bank¹²

¹¹ The WHO is a part of the UN system and is responsible for providing leadership on global health matters (WHO, 2007b)

¹² The WB is a source of technical and financial assistance to developing countries around the world (WB, 2007)

and the Institute of Medicine¹³, all of which have different interests. These institutions are large and have the capacity to conduct large scale studies, although each offers a limited point of view. Since most of the information originates from these three major organizations, any biases that exist are not addressed within the literature. The WHO, World Bank and the Institute of Medicine recognize the importance of psychosocial factors but continue to focus primarily on mental disorders and neuropsychiatric disorders, as opposed to overall mental health, also known in the literature as well being or wellness. This offers a very limited view of the nature of mental illness.

Social determinants of health

As mental health is both biological and social, social workers have a key role to play in the treatment of mental health issues. Social workers have the capacity to provide interventions to address the social aspects of mental health issues. When examining mental disorders such as schizophrenia and depression, there is a strong argument among authors for genetic transmission of susceptibility genes (Eisenberg, 1995). Eisenberg (1995), a physician researcher, however, argues that while there is a biological and heritable component to mental illness, this cannot account for the observed variances of outcomes in the course of the illnesses. For example, variations in housing, diet, education, work patterns and disease exposure can account for differences in outcomes for patients experiencing schizophrenia. Evidence indicates that persons who experience depression, schizophrenia, and obsessive-compulsive disorder present problems of both the mind (psychological) and the brain (biological). These two alter each other and

¹³ The Institute of Medicine provides “unbiased, evidence based, authoritative information and advice concerning health and science policy to policy makers, professionals, leaders in every sector of society and society at large” (IOM, 2007)

demonstrate that the brain/mind responds to biological and social factors (Eisenberg, 1995). In other words, while there is a genetic component to mental health, social experiences cannot be dismissed as they also play a role in shaping the brain. In his research, Eisenberg is anticipating the newly emerging field of *epigenetics* which studies how the environment influences and modifies genetics (Meaney, 2007; Meaney, Weaver & Szyf, 2007).¹⁴

In Canada, *The Lalonde Report* in 1974 established a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology, and health services. This set the stage for future developments in population health. The term population health recognizes social, economic and environmental factors that contribute to health and aims to improve the health of an entire population and to reduce health inequities among population groups (Health Canada, 2007b). A population health approach is meant to address the entire range of individual and collective factors that determine health. It emphasises that living and working conditions are crucially important for health, which includes mental health. Within the field of population health some key social determinants of health have been identified. In 2002, York University organized a conference called *The social determinants of health across the life span*. As a result of the conference, 11 social determinants of health were identified. These included aboriginal status, conditions of early life, education, employment and working conditions, food

¹⁴ Michael J Meaney is a James McGill Professor of Medicine at Douglas Hospital Research Centre of McGill University. He is the Director of the Maternal Adversity, Vulnerability and Neurodevelopment Project and of the Developmental Neuroendocrinology Laboratory of McGill University. Over this period Meaney's primary research interest is on the effects of early experience on gene expression and development. Meaney's research is multidisciplinary and includes studies of behaviour and physiology, to molecular biology and genetics. The primary objective of these studies is to define the processes that govern gene – environment interactions. He has authored over 250 journal articles and has been the recipient of a Scientist Award from the Canadian Institutes for Health Research (CIHR) and a Distinguished Scientist Award from the National Alliance for Research in Schizophrenia and Affective Disorders, among others.

security, access to health care services, quality of housing, income and its distribution, social safety net, social exclusion and unemployment and employment security (Raphael, 2004, p.6).

Internationally, the WHO Commission on Social Determinants of Health in its publication, *“The Solid Facts: Second Edition”* (2003) identifies stressful circumstances, stress in the workplace, job security/insecurity, friendship, good social relations and strong supportive networks as key determinants of mental health worldwide (Wilkinson & Marmot, 2003). When discussing mental health in developing countries, Patel (2007) identifies three key social determinants of mental health: loss, trauma and displacement as a consequence of conflict and disasters, poverty, and gender inequality.¹⁵ Poverty and gender inequality are contributing factors to the difficulties people will experience in conflict and disasters. Although the literature has identified these three as the key social determinants, social determinants of mental health will vary in each location. Within the international health literature, social change, neglected elderly, medical comorbidity; tropical diseases, and malnutrition and poor environment have been presented as other important social determinants of mental health (Patel, 2003; Desjarlais, 1995 & WHO, 2001a).

It is, therefore, widely accepted in contemporary literature that mental health is an outcome of psychosocial factors. Psychosocial interventions focus on these social factors and are therefore important for rehabilitation in mental health. Psychosocial rehabilitation is centred in large part on the “strong recognition that mental health problems influence

¹⁵ ‘Gender inequality’ is primarily understood as a women’s issue in international development (Hanmer & Naschold, 2000). This is because discrimination against girls and women including economic discrimination, gender based violence, reproductive health activities and harmful traditional practices remain the most pervasive form of inequality (UN, 2007d). Therefore, the term ‘gender inequality’ in this study is meant to represent the inequality that girls and women experience.

and are influenced by real life experience” and seeks to assist clients with individualized behaviour in social environments (Townsend, 1998, p. 105). While the biological aspect of mental health is often addressed by psychiatry, social workers are interested in and have the capacity to respond to the social factors.

Mental and psychosocial issues as a result of conflicts and natural disasters

Research indicates that as a result of bereavement, displacement, and loss of livelihood, the risk of mental health issues is especially acute during and post conflict and natural disaster (van Ommeren, Saxen & Samceno, 2005; Patel, 2007). These risks are amplified in developing countries because there is often an absence of infrastructure and human resources to deal with the aftermath of the event. Furthermore, post conflict and natural disaster, many humanitarian and international agencies focus their efforts on immediate needs such as food, shelter and other medical assistance, effectively ignoring what may be less obvious issues of mental and psychosocial well being. After reviewing many studies, Paykel (1978) concluded that, “in the months following a traumatic experience, there was a six-fold greater risk of a depressive disorder, and a slightly increased risk of a psychotic illness akin to schizophrenia” (Summerfield, 1991, p160).

Costs of war linger long after the war is over because violence and trauma increase risk of mental disorders (Baingana, F., Bannon, I., & Thomas, R., 2005; WB, 2004). Scholarly literature demonstrates that, in conflict situations, the incidence of psychiatric disorders is higher than the 1%-3% occurrence in the general population not exposed to war (Baingana, F. et al, 2005; WHO, 2001b; WB, 2004). The stress of the conflict situation may bring on symptoms that might otherwise be dormant. Additionally, violent

acts such as targeted killings, amputations, gender-based violence such as sexual violence against women, and physical maiming have long term psychological effects on those who witness them. Some symptoms include fear, sleeplessness, anxiety, anger and depression (Baingana, F., et al., 2005, p. 6). For ex-combatants, negative side effects include higher incidence of alcohol abuse, post-traumatic stress disorder (PTSD), anxiety and depression (Baingana, F., et al., 2005).

Internationally, a major concern is the refugee population. They are large in number and are faced with numerous risks of developing mental health issues. "In addition to the approximately 13.5 million refugees and 20 million internally displaced persons because of armed conflicts there are countless other economic and environmental refugees around the world" (de Jong, 2002, p.4). The potential short and long term mental health and psychosocial consequences of displacement include the sense of loss or deprivation of family, homeland, status, possessions, and culture as a result of attempting to cope with an unfamiliar environment (de Jong, 2002). The mental health of refugees is often affected negatively by their feelings of confusion, rejection and the absence of social supports within their new environments (de Jong, 2002).

The World Bank (2004) report "*Mental health and the global development agenda: what role for the World Bank?*" summarized several studies of the mental health consequences of conflict. On the Thai-Cambodian border, where there were 993 Cambodian refugees, 15% suffered from PTSD and 55% from depression (Mollica et al., 1993). Another example summarized was in Uganda where 55 internationally displaced persons (IDPs) experienced trauma while 58 IDPs did not. Of the trauma group, 53%

experienced PTSD, 62% experienced generalized anxiety disorder and 71% experienced major depressive disorder (Muller et al., 2002).

There are also mental health risks following an emergency such as a natural disaster. In addition to psychological problems such as PTSD, sleeplessness and depression, there are also psychosocial problems. These include preexisting problems such as extreme poverty and political oppression, and emergency induced problems such as family separation, disruption of social networks, destruction of community structures and increased violence against women. There are also humanitarian aid problems such as undermining of community structures or traditional support mechanisms (Inter Agency Standing Committee, 2007). The preexisting problems of poverty and oppression intensify the psychosocial effects of both conflict and natural disaster and can lead to a vicious cycle of mental ill health and poverty.

Poverty

Poverty and the lack of resources is a contributing factor to the difficulties people will experience in conflict/post-conflict and post natural disaster situations (IASC, 2007). In 1995 Desjarlais et al. estimated that one-fifth of the world lives in abject poverty. That is an estimated one billion people. Goldberg, D., Mubbashar, M. & Mubbashar, S. (2000) estimated that 1.2 billion people were living in abject poverty in 2000. There is scientific evidence that depression is 1.5 to 2 times more prevalent among low-incomes groups of population (WHO, 2003a; WHO, 2001a). Mental illness can depress cognitive function and therefore limit the ability of those affected to function at work or school without appropriate treatment. Therefore, these illnesses can, in turn, lead to depressed economic

circumstances, thus creating a vicious cycle of illness and economic deprivation (IM 2001; Desjarlais et al., 1995). Saraceno, B. and Barbui, C. (1997) believe epidemiological data can be summarized as “people with the lowest socioeconomic status (SES) have 8 times more relative risk for schizophrenia than those of highest SES” (p.285).

Unsafe and unhygienic living conditions are often exasperated in areas of conflict or where a natural disaster has occurred. Inadequate shelter, no sewage disposal, limited access to potable water, and attendant risk of diseases, which are commonplace in impoverished areas can cause epilepsy and developmental disabilities. Malnutrition is especially detrimental to unborn children and their future developmental (IM, 2001). Furthermore, the Institute of Medicine (2001) states that, “Malnutrition, physical illness, exposure to toxins such as alcohol and lead, perinatal injury, and lack of educational and social stimulation have been shown to adversely affect the cerebral mechanism of attention, which has been identified as a major source of cognitive deficits in school children” (p.36). Poverty can also have extreme psycho-social effects on families as it can cause ongoing anxiety and depression. Inadequate access to health care for brain disorders can lead to chronic disability and death (IM, 2001).

Without well targeted and structured investment in mental health, the vicious cycle of poverty and mental health disorders will be perpetuated, thereby preventing poverty alleviation and development (WHO, 2003b, p.25).

When combining the high levels of poverty in developing countries with the occurrence of conflict and/or natural disasters, the risk of developing mental health issues increases greatly.

Gender Inequality

Women have certain vulnerabilities during times of conflict and/or natural disaster (UN, 2007d). To begin with, unipolar depression, which is predicted to become the second leading cause of the global disability burden by 2020 is twice as common in women (WHO, 2007c). Additionally, depression among women in developing countries is intensified because of inequalities such as socioeconomic disadvantage, low income and income inequality, low or subordinate social status and unrelenting responsibility for the care of others (IM, 2001; WHO 2001, UN, 2007d). Incidences of rape, involuntary prostitution, sexual violence, loss of family members through death and disease, and not knowing where loved ones are, increase in times of conflict or natural disaster, creating an increased risk for depression among women. All these factors lead to emotional trauma and depression in women at higher rates than men (IM, 2001; WB 2004; WHO, 2001a). Victims of domestic violence can suffer from disabling and long lasting health effects, such as depression and posttraumatic stress disorder, as well as dissociation disorders, somatization, sexual dysfunction, and self-harm behavior (IM, 2001; WB, 2004). The risk of developing mental health issues among women in developing countries is therefore significant, particularly after traumatic incidences such as conflict and natural disasters.

Several social determinants of mental health can influence the outcome of overall mental well being and are therefore accepted as important in contemporary research. Three social determinants that are particularly important in developing countries are loss, trauma and displacement as a consequence of conflict and natural disasters, poverty and gender inequality. Issues of gender inequality and poverty in developing countries intensify the difficulties people in conflict or natural disaster situations experience. These

risk factors can affect numerous generations and result in a vicious cycle of poverty and mental health issues. Although the focus of this study is on mental health interventions, complementary responses including the provision of food and shelter in conflict/post conflict and post natural disaster situations are recognized as essential. Social workers focus on responding to social factors and providing psychosocial interventions and are therefore very important in helping to reduce the effects of these risk factors for the field of mental health rehabilitation.

Models of psychosocial intervention

Although the field of mental health and psychosocial interventions within international development is a relatively new one, there is a body of literature that indicates that the most operative interventions conflict/post conflict and post natural disasters are psychosocial (IASC, 2007; IFRC, 2003; PSWG, 2003a & IOM, 2000). Additionally, psychosocial interventions are the focus in the field of social work. Numerous international organizations and scholars have recently developed models of psychosocial interventions. In the current literature, much of the information regarding psychosocial interventions addressing mental health needs in the field of international development is focused on the needs of populations during or post-conflict as well as post natural disaster, extending into the reconstruction stage. The models presented in this literature review have been selected because they are proposed and implemented by influential organizations and by scholarly authors working in the area of mental health in international development. The organizations presented include: the Interagency Standing Committee, the WHO, The International Federation of the Red Cross/Red Crescent, the Psychosocial Working Group, HealthNet TPO (Transcultural Psychosocial Organization),

and the International Organization for Migration. Authors such as Agger (2001) and Lykes and Mersky (2006) who address conflict and post-conflict psychosocial interventions and reparations work are also discussed in this section.

Interagency Standing Committee

The Interagency Standing Committee (IASC) provides a forum for coordination, policy development and decision making involving key UN agencies, all of which are multilateral agencies and major players in the field of international development. The committee was created in 1992 and established as an inter-agency coordination of humanitarian assistance. Full members of the IASC include: Food and Agriculture Organization (FAO), United Nations Office for Co-ordination of Humanitarian Affairs (OCHA), UN Development Program (UNDP), UN Population Fund (UNPF), UN High Commissioner for Refugees (UNHCR), UN Children's Fund (UNICEF), World Food Program (WFP) and the World Health Organization (WHO). There are also numerous international humanitarian agencies that are standing invitees who work as partners in the decision making process.

The IASC has recently published (February 2007) "*Guidelines on Mental Health and Psychosocial Support in Emergency Settings*". The guidelines were created with the help of over 150 humanitarian agencies worldwide and therefore represent the viewpoint of many important agencies in the field of international development. In these guidelines, the composite term 'mental health and psychosocial support' is used to describe any outside interventions that protect or promote the psychosocial well being or treatment of mental illness of the affected population. This document provides a matrix of

interventions of Mental Health and Psychosocial Support (MHPSS) in Emergency Settings. After identifying functions or domains, interventions are provided such as, emergency preparedness, minimum response, and a description of what would be a comprehensive response. The domains identified are: coordination, assessment, monitoring and evaluation, protection of human rights standards, human resources, community mobilization and support, health services, education, dissemination of information, food security and nutrition, shelter and site planning, and water and sanitation.¹⁶

The IASC follows a set of core principles. The first is human rights and equity which states that mental health and psychosocial supports services should be available across affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs. The next principle is participation, where the belief is that communities are resilient and oftentimes key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies. ‘Do no harm’ is another principle suggested by the IASC. Humanitarian actors can reduce the potential for harm by: “coordinating with other groups to minimize gaps in response, performing evaluation by external reviewers, developing cultural sensitivity, staying up to date on evidence based effective practices, and understanding the value of participatory approaches” (IASC, 2007, p.7). To ensure sustainability, it is important to build on local capacities (government, communities, families, individuals) from the early stages of an intervention. Another key principle is the idea that psychosocial programming should be integrated into existing support systems. According to the IASC, activities that are

¹⁶ For the full matrix of interventions please refer to Appendix A: IASC Matrix of Interventions

integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma. The last key principle is to organize mental health and psychosocial services into a layered system of complementary supports that meets the needs of different groups (IASC, 2007).

The World Health Organization

The WHO is another important multilateral organization whose mandate is exclusively dedicated to health. Furthermore, the WHO is a large organization that often takes a leadership role internationally regarding health issues. In the past few years, it has taken a “population perspective” for addressing the magnitude of psychological distress and mental disorders post emergencies. This perspective was put forward after the Asian tsunami in 2004, where groups requiring a response were grouped into three different categories:

- 1) *People with mild psychological distress that resolves itself within a few days or weeks,*
- 2) *People either with moderate or severe psychological distress that may resolve over time, but other times becomes chronic. These people tend to be labelled with psychiatric problems, although the instruments used are not validated for the local context. These people would benefit from social and psychological interventions that alleviate distress.*
- 3) *People with mental disorders including mild and moderate depression and anxiety disorders and post traumatic stress disorder. Following a disaster, the rate of mental health disorders will increase between 5-10%. (WHO, 2005c)*

The WHO has developed a framework for the implementation of mental health and psychosocial support that contains four levels of intervention. The first and second levels involve the formation of a team for community mental health services. The

community mental health services can be provided through mobile/outreach facilities that are based in an acute ward in a hospital or through the current primary care system. This team would include one medical doctor with mental health skills, three nurses, and three technicians who are trained and supervised in non-medical psychosocial support. Levels three and four include involving and strengthening the capacity of the community. In these levels of intervention, families and individuals should also gain the capacity to care for themselves. This can be done through psycho-educational activities such as strengthening the support provided by pre-existing community resources, community participation activities that involve getting community members together in self-identifying and planning community activities to reduce mental and social suffering, activities that address important social factors to reduce social suffering, structured social services outside the health sector, and adding further strength to community networks through community activities (WHO, 2005c).

During the acute emergency stage the WHO recommends that social interventions do not interfere with other organization needs such as food, shelter, clothing, and control of communicable diseases. The reconciliation phase continues relevant interventions from the emergency stage but includes a larger education and capacity building component.

The International Federation of Red Cross/Red Crescent Societies

The International Federation of Red Cross/Red Crescent Societies (IFRC) is an international humanitarian organization dedicated to improving “the lives of vulnerable people by mobilizing the power of humanity” (IFRC, 2007). The IFRC is an important organization to include when reviewing the literature as it is the key multilateral

organization that responds to disasters worldwide. The organization has developed a “Psychosocial Framework 2005-2006”. The framework outlines how to serve the most vulnerable groups within communities in emergencies, rehabilitation and long term capacity – building programs (IFRC, 2005).

In the Psychosocial Framework 2005-2006, the IFRC supports a community-based approach to psychosocial interventions. They believe that, “it is important to recognise that communities have the capacity to help themselves through their own support networks and coping mechanisms (as opposed to a clinical or individual approach)” (IFRC, 2005, p.2). Specifically, the belief is that the majority of reactions following a disaster are natural and are not psychiatric illnesses. Therefore, programmes should respond to basic psychosocial needs in the community rather than the individual and should relate to everyday activities that have been identified by the community as useful.

The model proposed by the IFRC suggests an integration of psychosocial activities into other key intervention areas of Red Cross/Red Crescent (RC/RC) National Societies. The psychosocial interventions are meant to promote beneficiaries’ mental and social well-being and enhance community resilience. The first area of integration proposed is in *prevention/reduction of vulnerability*. The framework suggests the formulation of separate RC/RC Strategies at different stages of the intervention process such as emergencies, rehabilitation, and capacity building/development. The second area of integration is in the area of *disaster response* and suggests a protective approach that promotes local coping mechanisms and acknowledges the capacity for resilience within communities in disaster prone areas. Psychosocial components should be integrated into the Community Based First Aid (CBFA) and Community Based Disaster Preparedness (CBDP) programmes. In

terms of Strategic Actions, among other recommendations, the framework proposes that the IFRC establish assessment teams, and psychosocial specialists for emergencies, rehabilitation, long term programmes and interventions, and training to strengthen the ability to respond to psychosocial problems. One last area of psychosocial intervention is in *disaster response and rehabilitation*, where it is believed that disaster response attention should be directed to support survivors through emotional support and self help as well as strengthening local networks and institutions (IFRC, 2005).

The Psychosocial Working Group

The IFRC discussed above is a highly practice based organization where policies and guidelines are developed based on learned experiences in the field. The Psychosocial Working Group (PSWG), on the other hand, is a collection of academic institutions and humanitarian agencies committed to the development of knowledge and best practice in the field of psychosocial interventions conflict/post conflict and post natural disaster. Its members are committed to research and practice development (PSWG, 2007b) and include organizations/NGOs that could be funded through the partnership branch of CIDA. The group therefore adds a perspective based on academia and best practice, which is essential for a complete understanding of the field of psychosocial interventions. The institutions included in this working group are: Queen Margaret University College, Edinburgh, Institute of International Health Medicine; University of Oxford, Refugee Studies Centre; Christian Children's Fund; Columbia University, Program on Forced Migration and Health; International Rescue Committee, Program for Children Affected by Armed Conflict; Medecins Sans Frontiers, Holland; Mercy Corps; Save the Children

USA; Solomon Asch Centre, University of Pennsylvania and Harvard University, Program in Refugee Trauma. The Psychosocial Group has published numerous working papers. Two of these working papers, "*Psychosocial Interventions in Complex Emergencies: A Framework for Practice*" and "*Considerations in Planning Psychosocial Programs*" are meant to guide interventions.

During the preparation stage of psychosocial interventions, it is essential that a community's understanding of psychological issues is fully considered and the cultural integrity of the community respected. Interventions should attempt to fill gaps and stand alone psychosocial programs which are not integrated into a larger health intervention may be premature if the structure is not there to support it. It is also essential that programs take a critical perspective. This is because psychosocial interventions can have unintended impacts and should therefore focus on empowerment, engagement and capacity building to avoid creating a cycle of dependency.

Another consideration proposed by the PSWG is assessment. Ideally, assessments provide an understanding of people's experiences, identify the needs of the population, and ensure an ongoing analysis of the situation that is sensitive to cultural differences. To foster "ownership" by the local community and to ensure that the needs of the most vulnerable are met, the Psychosocial Working Group insists on local participation. Some other considerations are the ability of the program to build capacity, foster self reliance, use local skills, have well defined exit strategies to help ensure sustainability, and collaborate with local governments (PSWG, 2003b).

The PSWG believes that psychosocial programs can make significant contributions to the areas of peace building and social justice and should promote explicit

links between rights protection and emotional well being, address key protection issues and support and advocate for the establishment of local protection efforts. Another key component of programming described by the PSWG is evaluation and knowledge improvement. The field of psychosocial interventions is relatively new and needs to be strengthened and systematized through proper documentation and research to measure program effectiveness/impact and should be done using a participatory approach. Furthermore, training should be ongoing, take into account local cultural practices and prepare trainees for complex emergencies. Individual, social and cultural linkages promote the value to interventions at multiple social levels (individual, household, group), local views on well being should be considered, and where possible local social and cultural resources (rituals, healers, etc.) should be used (PSWG, 2003c).

HealthNet – TPO (Transcultural Psychosocial Organization)

“HealthNet TPO is a knowledge-driven, non-profit organization that works in areas disrupted by war, disasters and poverty” (HealthNet TPO, 2007). They work with local populations to channel emergency aid into sustainable health care development and, like the PWSG, could be funded through the partnership branch of CIDA. The approach taken by this organization is important since it focuses on war, disasters and poverty and is therefore closely linked to the purpose of this thesis which is to examine psychosocial interventions conflict/post conflict and post natural disaster. Furthermore, it provides the perspective of an NGO working in the field of psychosocial interventions in international development. HealthNet– TPO promotes a public mental health perspective as the most viable and useful model of psychosocial intervention in developing countries. The model

was designed to empower the refugee populations to “treat the unmet psychosocial and mental health problems of their members utilizing a community based culturally appropriate approach” (de Jong, 2002, p. 175). In the context of the local culture, Health Net - TPO assists to provide relief from distress and resolution within families and communities of refugees and internally displaced persons (IDP's).

The model has three overlapping and interconnected levels of intervention. The first level of intervention targets the community at large and is meant to have an effect on society as a whole. This level of intervention, often carried out by the international UN agencies, governments, politicians and policy makers, is aimed at the primary prevention of conflict, wars or disasters. Within this public health model, it is thought that international laws, national laws and public policy can influence the outcome of exposure of a population to traumatic events (de Jong, 2002). This level of intervention includes: defining and condemning traumatic events such as torture, setting standards for intervention training, arms and landmines control, war tribunals and the persecution of perpetrators, human rights advocacy and disaster preparedness training.

HealthNet – TPO suggests that the second level of intervention (or the community level) should target the total population of refugees and internally displaced persons (IDP's). This includes providing safety and shelter, empowerment of the community, and public education and capacity building. The aim is to reach the majority of the population through the work of NGO's, local governments or more specialized international agencies. Interventions require less specific expertise in the field of mental health or trauma treatment than the third level of interventions suggested (de Jong, 2002). Reparation and compensation, self help groups for ex-combatants and ex-soldiers,

survivors of rape, widows and others, and family/network building, counseling, individual, group and family therapy as well as pharmacotherapy are also provided at this level.

The third level of interventions within this public health model is directed to families and individuals. At this level, individuals who experience “active or chronic psychoses, depression, anxiety disorders or epilepsy” (de Jong, 2002, p.81) are treated. The goal of tertiary interventions is to reduce chronicity through active rehabilitation and public education. Treatment includes self help groups for the individual experiencing the chronic mental illness or epilepsy as well as self help groups for families, children and adults with handicaps. Within this model, the tertiary level of intervention means reducing relapse and stimulating rehabilitation. Furthermore, it is recognized that the sociopolitical context including factors such as human rights, governance, politics, environment, culture, traditions, socio-economic status and religion influence each level of intervention (de Jong, 2002).

The International Organization for Migration

An example of an organization that may be funded through the multilateral or bilateral branches of CIDA is the International Organization for Migration. “The International Organization for Migration (IOM) is an intergovernmental organization established in 1951. IOM is committed to “the principle that humane and orderly migration benefits migrants and society” (IOM, 2007, n.p). The IOM’s focus on migrants, refugees, and internally displaced persons (IDP’s) offers a different perspective from those organizations that address victims of conflict and natural disasters more broadly.

The IOM has done the majority of its work with those affected by the Kosovo war. Their model of psychosocial intervention post conflict has been applied in many of the areas affected and provides a solid example of the implementation of the model. In response to the war in Kosovo and the resulting mental health issues associated with the aftermath, The IOM organized the *Psychosocial and Trauma Response (PTR) Project*. The project proposes a shift from individualistic trauma approaches to working with the entire community. What this implies is "... the awareness that each of us, within our community, must constantly rediscover what constitutes trauma for the specific group, and create a strategy for treatment accordingly" (Losi, 2000, p.15). The idea is that psychotherapists must work with individuals and entire communities to promote empowerment rather than encourage victimization or the importation of Western models of health.

The approach of the *IOM Project on Psychosocial Trauma* is based on the "learning through practice" approach inspired by Paulo Freire's pedagogical ideas. For this model, there are three principal axes of intervention: psycho-sociocultural, historical-anthropological, and clinical. The divisions among these categories are not meant to be rigid but instead fluid and interchangeable. The psycho-sociocultural axis included a project called the Archives of Memory. This project worked to show students that the recollection of sharing of painful, sometimes traumatic experiences and shifting these memories from the individual to the group allowed for a certain de-psychiatrization. Another element of this first axis was a project called *The Exiled Body*. This component strengthened solidarity of the group and their group members' conviction that they were

doing something they believed in; something to which they were strongly committed (Losi, 2000).

The Archives of Memory project also addressed the second axis suggested by the IOM, the historical - anthropological axis. The project was intended to ensure that stories of suffering created by the war were recorded, expressed and preserved within their sociocultural context. The hope was to avoid a 'monolithic' or public memory thus hoping to avoid traumatizing those who were excluded from the 'official' recollection. By mingling memories from different sides of the conflict, the project gave participants the chance to know themselves through the views of others which was meant to strengthen the individual and collective identity. The Archives were also meant to preserve the archives of the war. "The Archives of Memory are thus a place where past experiences might be experienced again, as a new way to understand the present, and yet this library of retrospection also holds hope for the future" (Salvatici, 2000, p.128). It has allowed people to externalize their memories.

The third axis suggested by the IOM is the clinical axis. Within this approach there is seen to be a shift from the conventional method of clinical interventions to examining the cultural and spiritual context in which the patient lives. Since this is a different approach than what is generally considered a 'clinical' intervention, the patient and therapist must find new methods of interaction. Patients are encouraged to refer (consciously or otherwise) to a traditional and familiar thought and understanding of the world that includes theories of illness and cure. The IOM believes that the cause of a patients' confusion is often external and "their personal disturbance can then be described as a reflection of a rupture in their bond to their family and community" (Losi, 2000,

p.19). The therapist/social worker acts as a mediator between the patient and their environment. This type of intervention allows the patients to see their disturbance/confusion according to their own cultures. The ultimate goal of counseling is to renew a sense of belonging, to renew family bonds, re-enter their original family and social networks (Losi, 2000, p.19).

War and post war psychosocial interventions

While the IOM focuses its attention on the victims/survivors of the Kosovo war, Agger (2001), a psychologist associated with the Institute of Cultural Sociology, University of Copenhagen and the OASIS Treatment and Counseling Centre for Refugees, Copenhagen, Denmark is an author often cited in the literature who focuses primarily on psychosocial conditions in times of conflict and post conflict. Her research does not address conditions resulting from natural disasters. In her opinion, during war-time, interventions should be defined and implemented in this order: 1) political, economic, and physical survival, which are at the baseline; 2) community development interventions, such as the establishment of an orphanage for homeless or unaccompanied children; 3) task oriented interventions, such as language courses or other types of occupational or educational activities; 4) psychologically oriented group interventions, such as organizing women's self help groups; 5) counselor interventions, such as working with a social worker; 6) and intensive psychotherapy, such as individual or group therapy by psychologists or psychiatrists where long term emotional problems are addressed (Agger, 2001).

Agger (2001) suggests a different order of intervention under post war conditions:

1) community-oriented interventions, such as organizing meetings for ethnically mixed groups discussing neutral topics of mutual interest; 2) task oriented interventions, such as organizing education in human rights; 3) psychologically-oriented group interventions, such as creating self help groups for family members of the missing; 4) counseling interventions, such as providing individual or group consultation around present dilemmas concerning the return process; 5) and intensive psychotherapy interventions, such as providing individual or group therapy in which deeper emotional problems are addressed such as the mourning of loss and the process of forgiveness (Agger, 2001, p.249).

'Alternative' Framework

A recent psychosocial framework developed has been coined by authors Lykes and Mersky (2006) as the 'alternative' framework in the area of reparations work. Reparation programs seek to heal individual and social wounds resulting from war and are therefore significant when examining post conflict interventions. Unlike Agger (2001), who addresses psychosocial health in times of conflict and post conflict, Lykes and Mersky (2006) focus solely on post conflict situations. The 'alternative' framework links the need for psychosocial programming in reparations with fundamental human rights. The *'Principles and Guidelines on the Right to Reparation'*, prepared by the United Nations Commission on Human Rights in 2000, and still under consideration, establishes four broad forms of reparations; 1) restitution, 2) compensation, 3) rehabilitation, 4) satisfaction and guarantees of non-repetition. Mental health is addressed directly within the area of compensation which should address "physical or mental harm, including pain,

suffering and emotional distress” and rehabilitation which should include “medical and psychological care.”

Lykes and Mersky (2006) support a psychosocial orientation to reparations programming addressing war, post-war and transitional situations that are shaped by individuals, families and groups in their neighborhoods, their communities, their towns and cities and their societies. Furthermore, psychosocial reparations work should be integrated and enacted within specific historical, cultural and sociopolitical contexts. This alternative framework developed by Lykes and Mersky (2006) hopes to offer a means to address individual suffering but also an understanding that individual and social healing are both dependent on rebuilding, in new terms, the social relations and the moral boundaries that were destroyed during times of conflict.

The three principles that are central to this alternate framework are: the individual-community dialectic, the importance of thinking culturally about social experiences, and the victim/survivor as historical agent. Central to the individual-community dialectic is, “An exploration of the ways in which the relationship between the individual and society varies across cultures is one important step in reorienting psychosocial war torn societies” (Lykes & Mersky, 2006, p. 601). Remembering this principle, psychosocial assistance should be developed through communities because communities are places where individuality and collectivity are co-constructed. Whether individuals within communities are relatively autonomous and independent in Western countries such as Canada and the US or relatively interdependent in many Asian countries and much of Latin America (Lykes & Mersky, 2006) social relations are most frequently expressed in and lived through communities. This should be addressed when providing psychosocial assistance.

The second principle outlined by Lykes and Mersky (2006) is the idea of 'foregrounding' culture. Diagnosing and listing symptoms does not do justice to the cultural experience of politically generated trauma. For example, the burning of crops means that what has been destroyed is broader in scope (i.e. the collective and cultural) than the individual or his or her intrapsychic pain or trauma. "The destruction of cultural archetypes and metaphors annihilates or deeply limits the next generations' possibility of affirming aspects of their cultural life, so that psychosocial trauma is, once again, extended in time" (Lykes & Mersky, 2006, p.603). Only a deeper understanding of indigenous life and traditions can yield more adequate theories for work with these survivors. At the same time, Lykes and Mersky (2006) suggest that local traditions and cultures are not static and should not be accepted uncritically. It is therefore necessary to involve a diversity of practitioners (including those from the local community) with different theoretical and world views when designing psychosocial interventions. The 'alternate framework' therefore "foregrounds culture to better accompany individuals and societies in transition from war and seeking reparations" (Lykes and Mersky, 2006, p.605).

The third principle outlined in this 'alternative' framework is one of historicizing the victim/survivor. Historicizing the victim/survivor involves recognizing the importance of reconstructing identities for victims/survivors and their children in historical and social terms and providing some explanation of what happened to them (Lykes & Mersky, 2006, p.605). This offers an opportunity to rehumanize victims/survivors in their societies. The idea of historicizing responds to the challenge of transgenerational issues and what might be called social healing as a consequence of war. Historicizing of victims will depend on

the methods chosen by people to speak about their own experiences and about those that were lost. "Testimony, narration, and storytelling can be key in the effort to locate victims/survivors in a specific historical context and reconstruct their identities and roles in that context" (Lykes & Mersky, 2006, p.605). These three principles are not meant to be rigidly followed in each situation but instead offer a lens through which to engage with a group of victims/survivors and/or a local community.

An important cross cutting theme suggested by Lykes and Mersky (2006), is the importance of who is providing services in the community. They suggest it is important to have an interdisciplinary and intercultural team to plan psychosocial reparations processes within communities. This includes the importance of local or indigenous workers in the design and implementation of the program. Furthermore, the framework recognizes the potential of local communities and their leaders. These collaborative strategies help to situate the problems within their socio-historical and cultural contexts.

The literature presented represents viewpoints of multinational organizations, NGOs, working groups and scholars on the most effective and important psychosocial interventions during conflict/post conflict and post natural disaster. The representation of these models is a reflection of the literature available on the topic, which is focused primarily on post disaster and conflict/post conflict situations.

Conclusion

Social workers are ideally situated to play an important role in the area of mental health in the context of international development by addressing the individual and social dimensions of well-being through psychosocial interventions. Poverty and gender

inequality are identified as contributing factors to the difficulties people will experience in conflict and disasters. The risk of mental health issues is especially acute during conflict/post conflict and post natural disaster situations and is amplified in developing countries because there is often an absence or deficiency of developed infrastructure and human resources to deal with the aftermath of the event. The risk of developing mental health issues increases greatly when combining the high levels of poverty and gender inequality issues in developing countries with the occurrence of conflict and/or natural disasters. The high prevalence and global burden of mental health issues combined with a lack of human resources present a growing problem for the developing world.

In the field of international development, psychosocial interventions are a relatively new occurrence. A variety of viewpoints and models of psychosocial intervention were presented in this literature review. As discussed, the IASC has created a set of guidelines for mental health and psychosocial interventions that has been agreed upon by all of the UN Agencies. On the other hand, the WHO provides specific levels of intervention and is particularly good at addressing different levels of psychological distress. The IFRC believes that most reactions after a disaster are natural and therefore focus on building the capacity of communities. The PSWG is useful in providing the perspective of academic institutions combined with humanitarian agencies involved in delivering psychosocial services in the field. There are also several organizations that provide a clear focus on specific areas of psychosocial intervention. The focus of HealthNet –TPO is to strengthen the health care system by using culturally appropriate and culturally based approaches while the IOM focuses on migrants and refugees affected by the Kosovo war. Their project in Kosovo proposes a shift from individualistic trauma

approaches to working with the entire community. Other authors discussed in this literature review have developed models of psychosocial intervention that target specific populations. For example, Agger (2001) has developed a framework for conflict/post conflict situations while an 'alternative' framework suggested by Lykes and Mersky has been created for the area of reparations work.

The literature is short of studies on effectiveness but as the field continues to develop, research and practical experience should help to assess program effectiveness. It is significant that the majority of the literature pertaining to psychosocial interventions in international development relates to conflict/post conflict or natural disaster situations. While interventions post conflict and post natural disaster are undoubtedly important, the shortage of literature addressing other areas may be indicative of a lack of attention to other important issues such as ongoing abuse or alcoholism, a lack of mental health resources in certain areas or regions, or other mental health issues that could arise from living in poverty. The absence of literature representing psychosocial interventions in other areas of development could mean there is a general unawareness and lack of importance being placed on addressing ongoing psychosocial issues in developing countries that are not a result of conflict or natural disaster.

Chapter IV: Methodology

Introduction

The purpose of this exploratory study was to determine the mental health component in the context of international development and to explore the importance of mental health in the international development agenda of CIDA. The importance of mental health was explored in terms of what areas of mental health are funded by CIDA, what proportion of their overall budget is dedicated to health and what proportion of this health budget is dedicated to mental health.

The study applied two qualitative methods to analyze the data: grounded theory and content analysis. Grounded theory uses a methodological process that supports the generation of theory that is based on data systematically gathered and analysed (Glaser & Stauss, 1967) and is therefore highly applicable to qualitative studies. Following the grounded theory process, content analysis will be used for further analysis of the data. The method of content analysis enables the researcher to include large amounts of textual information and systematically identify its properties, e.g. the frequencies of most used keywords (concept analysis, also known as *thematic analysis*) and relationships between the concepts identified (relational analysis, also known as *semantic analysis*).

The methodology for this thesis was conducted in three steps. The first step involved the data collection procedures which included a search for available documentation of projects that CIDA has funded from the year 1995 up to the present that contain a component of mental health. The second step was to determine which project abstracts were to be used as the sample. Applying the concepts of grounded theory and content analysis to these project abstracts was the third step.

Data Collection Procedures

Document search

The aim of the document search was to determine what areas of mental health were funded by CIDA. I contacted an employee of CIDA working in the Information Management and Technology Branch, Corporate Reporting Services Group, who was able to provide me with his assistance in searching within the database system at CIDA that contained a record of all the project abstracts. The search uncovered seventy-six records using the search descriptors: Mental illness, mental disorders, psychological trauma, psychiatric conditions/epidemiology, psychiatric illness, depression, suicide, bi-polar, schizophrenia, alcohol and drug abuse, psychosis, psychological effects of violence (physical assaults, robbery, rape, gang related activities, torture, war, displacement, etc.), eating disorders, psychiatric hospitals, dementia, inpatient/outpatient services psychiatric hospitals, brain/behavioural disorders, human resources for mental health, and counselling.

From these seventy-six project abstracts I then eliminated the records that included the search descriptors but focused on areas that were not pertinent to my study, such as 'environmental health'. I also eliminated project abstracts that included the term 'health' but were not related to any of the above terms in any other way. Some examples include nutritional health, indigenous health, and basic health care. I then eliminated any project abstracts that began or finished before 1995 as well as project abstracts that finished after 2005. Projects that finished before 2005 were chosen because they are complete and their project abstracts provided a clear picture of what had occurred in the duration of the project. Furthermore, I eliminated project abstracts that did not receive any funding during the time under study as these were not pertinent to my study. Finally, I eliminated project

abstracts that included one of the descriptor terms in the mandate of the organization undertaking the project (for those projects funded through the Partnership branch) but did not include any descriptor terms in the goals or activities of the specific project being outlined. Regardless of the overall mandate of the organization receiving funding from CIDA, if the project goals or activities did not include a component of mental health, they were not pertinent to my study. This process of elimination left thirty four project abstracts funded between 1995 and 2005 which included mental health descriptors.¹⁷

After reviewing these thirty four projects in further depth, there were ten projects that focused solely on mental health. The other projects contained a component of mental health but also included various other objectives. The goal was to obtain the ten full project reports including the PAD (project approval document) and any evaluations that occurred after the completion of the project. A detailed analysis of these ten full project reports which focused solely on mental health would provide a clear picture of CIDA's contribution to policy and programming in the area of mental health.

The first method I explored to obtain the full project reports was to contact ATIP (Access to Information Program) at CIDA. I was informed that a formal request for all information regarding the projects would take eight months to one year. The already overwhelmed staff in the ATIP department had to first locate all the information and then review each project carefully to ensure the project descriptions and associated information did not contain information that could not be made public. Since the time frame of eight months to one year would have made it impossible to finish my thesis on time, I sought alternative methods for obtaining the data. An employee of the ATIP department

¹⁷ Please see Appendix B: Initial Open Coding Process for a full representation of the open coding process that was undertaken on these 34 projects.

suggested I request the documents informally and to limit my search to certain documents. An informal search would mean that the department would not have to follow the protocol required of a formal request. I had initially been searching for any information referring to the projects including the project approval documents (PAD), and any evaluations of the projects. At this point, I limited my search to the PAD (Project Approval Document) which provides the intention of the project and therefore represents the areas of mental health funded by CIDA. The three employees at ATIP were overwhelmed with requests from many government employees and politicians and despite my numerous attempts to contact the ATIP department in the following months; I was not able to get any information from ATIP at CIDA.

The next method I explored to obtain the ten PADs was to search internally in CIDA's database system. It was only possible to search for the projects funded by the multilateral and bilateral branches as projects funded by the partnership branch are not recorded using the internal database system. Of the ten projects, one was funded by the multilateral branch, three were funded by the bilateral branch and the remaining six were funded by the partnership branch. At my request, the director of the Caribbean Division in the Americas Branch was able to search for the multilateral (one project) and bilateral projects (three projects) internally through the CRAFT system. Unfortunately, two (one multilateral and one bilateral) of the projects could not be located through the CRAFT system and one (bilateral) was located but did not contain any information. One full project PAD, funded through the bilateral branch, was available through this CRAFT system.

After only locating one full PAD through the CRAFT system, the Director of the Caribbean Division in the Americas Branch began to search for specific project officers in the regions addressed in the projects who may have been able to provide information about the PADs.

The other six projects had received funding from the Partnership Branch. This means that funding was given by CIDA to NGO's to undertake these projects. The Director General of Strategic Planning and Policy Directorate (Partnership Branch) directed me to the Policy Analyst, Geographic Coordination and Corporate Planning, Strategic Planning and Policy Directorate to appeal to for assistance. On March 26, 2007, I received an email from the Policy Analyst, Geographic Coordination and Corporate Planning, Strategic Planning and Policy Directorate indicating that no information was available in the public domain on the projects but he was able to provide me with the names and contact information for the majority of the NGO's involved in the projects. The next step was to appeal to each NGO directly for the project information.

I then began to contact the NGOs via email and telephone to enquire about obtaining the PADs or any other information available on the projects. Following the process of telephoning, one full project report was made available to me from one NGO. The project report I received was not a PAD, but instead an informal report created by the NGO. After only one response, a formal letter requesting information signed by my thesis supervisor was sent to each NGO via email. I attempted numerous times following this email to contact the NGOs via telephone and email. Several NGOs were not able or willing to provide me with any information while other NGOs did not respond to my requests.

After five months of searching for these ten PADs, it became clear it was not going to be possible to obtain the reports necessary to conduct the study in the time frame allotted. The search had initially included projects between the years of 1995-2005. After these difficulties, I expanded my search to include projects from 2005 to present. Since I had previously decided to search for the PADs and not the evaluations of the projects as well, this meant it was possible to search for projects that took place after 2005 because it was not necessary for the projects to be completed in order to obtain the PAD. On May 22, 2007 I met with the Health Specialist in the Partnership Branch for assistance in locating three new projects I had identified from 2005 to the present that were devoted solely to mental health. The Health Specialist in the Partnership Branch contacted each department and specific officer concerning the projects I was searching for. This search provided me with no additional information. I therefore had only one PAD to analyse and one informal report. This was not sufficient information so in collaboration with my thesis supervisors, the focus of the analysis shifted from the analysis of the PADs to the analysis of the thirty four project abstracts obtained in the initial search.

In the process of conducting the initial analysis of the thirty four project abstracts, I discovered that the majority of the projects contained components of psychosocial interventions, although only six of the projects used the explicit terms 'psychosocial', 'psycho-social' or 'psycho-sociale'. For this thesis, psychosocial is conceptualized as an intervention within mental health and I therefore felt it was important to include 'psychosocial' as a search descriptor. Again, I contacted the employee of CIDA working in the Information Management and Technology Branch, Corporate Reporting Services Group, who was able to provide me with his assistance in searching within the database

system at CIDA that contained a record of all projects with the search terms 'psychosocial', 'psycho-social' or 'psycho-sociale'. The search uncovered eighty five (85) records with these search descriptors. Seven of these abstracts had both the explicit term 'psychosocial' as well as one of the descriptors searched under 'mental health'¹⁸.

Sample

The sample included thirty four project abstracts from the 'mental health' search and the eighty five project abstracts from the subsequent 'psychosocial' search. Taking into account that there was an overlap because seven of the project abstracts discovered from the 'psychosocial' search had also been uncovered in the 'mental health' search, this made for a total of 112 project abstracts. I then grouped these project abstracts, all of which had a component of mental health (including psychosocial interventions), into groups according to the population addressed or area of intervention. These groups include projects that address: basic mental health training (5 projects), community mental health (3 projects), conferences (2 projects), drug abuse and addictions (2 projects), childhood education (2 projects), elderly (1 projects), gender based violence (5 projects), HIV/AIDS (8 projects), human resource development (7 projects), internally displaced persons (1 projects), integration of mental health into the public health system (2 projects), literacy training (1 project), people with disabilities (1 project), reintegration into society (3 projects), schizophrenia (2 projects), strengthening

¹⁸ For the remainder of the methodology section the '**mental health**' search will encompass: mental illness, mental disorders, psychological trauma, psychiatric conditions/epidemiology, psychiatric illness, depression, suicide, bi-polar, schizophrenia, alcohol and drug abuse, psychosis, psychological effects of violence (physical assaults, robbery, rape, gang related activities, torture, war, displacement, etc.), eating disorders, psychiatric hospitals, dementia, inpatient/outpatient services psychiatric hospitals, brain/behavioural disorders, human resources for mental health, and counseling. The '**psychosocial**' search will encompass: 'psychosocial', 'psycho-social' and 'psycho-sociale' as a specific form of intervention, i.e. response to the problem.

institutional/organizational capacity (3 projects), women's rights (7 projects), youth and children (10 projects), conflict/post conflict (24 projects) and post natural disaster (23 projects).

The conflict/post conflict and post natural disaster categories were the largest with twenty four and twenty three respectively and when combined comprise 42 % of all projects found. Following the ideas of content analysis (to be explained further in the "Method of Analysis" section of this chapter), which quantifies the presence of words and concepts, the data indicates that the projects given a large percentage of importance are those that address conflict/post conflict and post natural disaster situations. Furthermore, a large majority of the literature pertaining to mental health in international development is focused on these two areas of conflict/post conflict and post natural disaster situations. Concentrating my analysis on project abstracts that contain a component of mental health in these two areas of intervention served to provide a more focused study.

As these project abstracts provided a limited amount of information about the projects, the PAD I received from my search was coded and analysed to provide further information to determine whether or not the project abstracts provide an accurate representation of the intention of the project. The project abstract for the PAD chosen appeared in both the 'mental health' and 'psychosocial' searches and was therefore a good representation of projects funded by CIDA. The sample for analysis was therefore forty seven project abstracts and one PAD.

Method of analysis

I analyzed the data using grounded theory and content analysis. I used a qualitative research analysis program called NVivo to code and organize the data. NVivo is a research software that helps access, manage, shape and analyse detailed textual information. NVivo offers tools for classifying, sorting, and arranging information. The project abstracts were each entered separately into the program in electronic form. The advantage of using NVivo is that the coding process is simplified and the program keeps the information well organized. It also meant that I could cross reference variables, categories, and nodes easily, thus providing a more in depth analysis. All the coding that used methods of grounded theory and content analysis were performed using this program.

In order to begin the analysis, the methods of grounded theory were used on all forty seven project abstracts to identify common words and phrases. The next step was to conduct a content analysis to identify the major trends and themes. For example, I looked for general mental health themes, regions of the world where the projects have taken place and significant findings in regards to budget allocations. I then wrote an analysis based on these findings.

Grounded theory

Grounded theory is a theory that is developed inductively from a corpus of data (Borgatti, 2001). For this thesis, the corpus is the forty seven project abstracts and the one full PAD. Each case (project abstract) is meant to be a whole, in which the variables interact as a unit to produce certain outcomes (Borgatti, 2001). Therefore, each project

abstract was coded as a separate entity. According to grounded theory, during the coding process certain theoretical propositions will emerge. Theories emerge through links between categories, or about a core category which appears central to the study. As the categories and properties emerge, they and their links to the core categories provide the theory (Glaser & Stauss, 1967). In this study, I used grounded theory as the first step to lead into the next step of content analysis.

Open coding is the first step in the grounded theory process. The open coding process is meant to identify key descriptors (words or phrases) in the project abstracts. I began coding words and sentences (descriptors) that were important to the topic of this thesis, that is, anything related to mental health and/or psychosocial interventions. Coded descriptors are called nodes in NVivo and contribute to the development of a category. In order to develop categories, the open coding process was repeated several times until patterns emerged in the nodes and categories could be created by grouping these nodes. The categories change continually as the open coding process advances (final categories are presented in Chapter V: Results).

The open coding process reflected that many of the project abstracts had a component of psychosocial even if the explicit term 'psychosocial' was not used. This meant it was necessary to define psychosocial in order to determine which categories could be seen as such. The definition I chose was the one presented by the PSWG (Psychosocial Working Group) which views psychosocial as the interaction between human capacity, social ecology and culture and values.¹⁹ According to the PSWG, in

¹⁹ The PSWG defines the term psychosocial as the emphasis between the "close connection between psychological aspects of our experience (our thoughts, emotions and behaviour) and our wider social experience (our relationships, traditions and culture)" (PSWG, 2003a, p.1). Psychosocial well being therefore involves human capacity (includes the physical and mental health of a person as well as his or her

order to determine whether an intervention is psychosocial the researcher should ask, “does the intervention promote human capacity or the social ecology of a community or contribute to people’s efforts to re-establish culture and values in some way?” (PSWG, 2003b, p.2). The categories I had created from the open coding process were represented well in this definition. I therefore adopted human capacity, social ecology and culture and values as headings for three of my categories.

From this open coding process I developed *core categories*, which are categories mentioned with high frequency and are well connected to other categories (Glaser & Stauss, 1967). Although ‘health’ became a clear category in my open coding process, I chose not to use ‘health’ as a core category to allow the focus to remain specifically on mental health in order to create a stronger analysis more geared towards the research question. In addition to the categories, several variables arose as being important. Whereas categories are created by the researcher by creating groups of nodes, variables are pre-existing (ex. region, type of funding) and nodes such as Sub Saharan Africa are categorized under the appropriate variable. For example, the node of Sub Saharan Africa would be coded under the ‘region’ variable.

The process of content analysis was used to analyse the projects and the relationships in greater detail. I examined the general mental health themes, the regions in which the projects have taken place and their budgets. Finally, by applying conceptual and relational analysis I gave specific attention to the underlying theoretical assumptions of the selected projects.

knowledge and skills), social ecology (refers to the social connections and support that people share and that form an important part of psychosocial well being) and culture and values (points to the specific context and culture of communities that influence how people experience, understand and respond to events).

Content Analysis

Content analysis (also called: *textual analysis*) is a research tool used to determine the presence of certain words or concepts within texts or sets of texts.²⁰ Ole Holsti (1969) offered a broad definition of content analysis as "any technique for making inferences by objectively and systematically identifying specified characteristics of messages" (p. 14). Researchers quantify and analyze the presence, meanings and relationships of words and concepts, then make inferences about the messages in the texts (Weber, 1990).

The method of content analysis enables the researcher to include large amounts of textual information and systematically identify its properties, e.g. the frequencies of most used keywords (concept analysis, also known as *thematic analysis*) and relationships between the concepts identified (relational analysis, also known as *semantic analysis*). The process of content analysis identified the frequencies of the most used keywords and the concept of semantic analysis could then be used to identify the relationships between concepts. In order to identify these relationships, queries were executed in NVivo. The queries executed in NVivo represent the co-occurrence of categories, nodes and variables by cross referencing two nodes, a variable and a node, a category and a node, a category and a variable, two categories or three categories. In order to build inferences, textual information must be categorised according to a certain theoretical framework. In this case the theoretical framework of psychosocial intervention as defined by the PSWG is used. Every grounded theory and content analysis also should depart from a hypothesis. ***My hypothesis is that the international development policies and programming of CIDA***

²⁰ Texts can be defined broadly as books, book chapters, essays, interviews, discussions, newspaper headlines and articles, historical documents, reports, speeches, conversations, advertising, theater, informal conversation, or really any occurrence of communicative language.

will be informed by the current international policy framework that addresses mental health issues through a psychosocial theoretical perspective.

The last step of the analysis was to analyze the PAD in detail. The analysis of the PAD involved the use of grounded theory and content analysis to develop categories within the project. I then compared the results of the analysis of the PAD to the results of the analysis of the project abstracts that represented the same project. This was meant to determine whether the project abstracts provided an accurate representation of the project details.

Methodological limitations

One methodological limitation of this study is the lack of information made available to the public by CIDA. Although technically the full project reports for which I was searching were available, the time frame for which they could be delivered was eight months to one year. As a Master's student who has one year to complete a thesis, waiting eight months to one year for the data was not an option. This limitation of a lack of project information also extended to the NGOs as only one of the six NGOs approached provided project information. This was likely due in part to the employees at these agencies being overworked and unable to find the time to locate these documents. The lack of project reports made available was a methodological limitation because these full project reports may have provided a richer information source in which to conduct the analysis.

Another possible methodological limitation is that each officer working on the specific project at CIDA used their own discretion as to what to include in the project abstracts. Since there are no set guidelines for what should be included in the project

abstracts or what is considered mental health in CIDA, this allows project officers to include what they deem important in the project descriptions. This presents a possible methodological limitation because project officers may omit information that I would deem important for my study. As I can only code and analyse the information presented to me, my analysis was therefore based on a certain level of subjectivity inherent in the recording of the project abstracts by CIDA officers.

A third limitation/influence is that my understanding of psychosocial has been influenced by my social work education. This could present a possible bias in the manner in which I coded the project abstracts. It is inevitable that a researcher will bring preconceived ideas into the research process. The manner in which my preconceived notions may have influenced the research process is in the coding process. It is possible that my social work education influenced my conceptualization of what is included in psychosocial interventions which would have influenced the open coding process as well as the analysis.

One final limitation is that textual analysis is limited to the understanding of the text, while interviews with project participants would provide the lived experience of the implementation and/or evaluation of the project. Since I did not conduct interviews, my conclusions are based solely on the project abstracts and PAD without the benefit of the lived experience. It is possible that the conclusions drawn would have been different if interviews with project participants had been conducted.

Chapter V: Results

Introduction

In the results section I present a selection of the raw data obtained through analysis of CIDAs project abstracts.²¹ I will also present the categories, variables and nodes identified through the open coding process. As described in the methodology chapter, following grounded theory approaches, I have applied to these project abstracts the process of open coding which generates categories, variables and nodes. Once the categories, variables and nodes are derived from the raw data, I performed a series of queries to advance a content analysis of the texts. The subsections included in this results section are: a) the regional distribution of projects, b) the amount of funding budgeted to projects, and c) CIDAs mental health budget. Following the presentation of these discrete variables, I will describe the d) open coding of the text, including the categories, variables and nodes and e) queries. My data will be presented in both numeric and graphic form. I coded forty-seven (47) project abstracts and of the forty-seven, twenty-four (24) addressed conflict/post conflict situations while twenty-three (23) addressed post natural disaster situations. Each project abstract was coded as its own separate entity.

Distribution of project abstracts according to region

In the project abstracts addressing conflict/post conflict situations, the regions of Sub Saharan Africa, North Africa and the Middle East, Eastern Europe, the Americas and Asia were represented. The percentage of project abstracts categorized in each region is as

²¹ Please see Appendix C: Complete List of Project Abstracts obtained through my search of CIDA's databases.

follows: The region with the highest number of projects is Sub Saharan Africa (25%), followed by North Africa and Middle East and Eastern Europe both with 20.8%, the Americas received 12.5% of CIDA's projects and Asia received the smallest number with 4.2 %. In the project abstracts that addressed post natural disaster situations, the Americas, Eastern Europe and Asia were represented. The region with the highest number of projects is Asia (74%). Both the Americas with 22%, and Eastern Europe with 4.2% received much smaller percentage of projects.

Percentage of project abstracts in each region – comparison between conflict/post conflict and post natural disasters

Bar graph #1

As represented in this graph, the majority of projects address post natural disaster situations in the Asia region. The distribution of projects is more even in the Americas, where the percentage is slightly higher for post natural disasters. The three regions of Eastern Europe, Sub Saharan Africa and North Africa and the Middle East have similar distributions with the majority of projects addressing conflict/post conflict situations and a small number addressing post natural disaster situations.

Amount of funding given to projects addressing conflict/post conflict and natural disasters

Twenty five percent (25%) of the projects addressing conflict/post conflict received up to \$200 thousand. The number fell to 20.8% for the third budget interval of \$500 thousand to \$999 thousand. Just below that percentage, 16.7% had \$1million to \$2.9 million budgeted, and 16.7 % had \$7 million to \$10 million budgeted. Twelve point five percent of projects (12.5%) received an overall budget of \$200 thousand to \$499 thousand. Only 8.3% of projects received amounts in the \$5 million to \$6.9 million budget interval.

In the post natural disaster projects, 22% received up to \$200 thousand. The percentage remained the same at 22% for the budget intervals of \$500 thousand to \$999 thousand and \$1 million to \$2.9 million respectively. The percentage of projects fell after these two intervals with only 12.5% percent of the projects receiving funding in the budget interval of \$200 thousand to \$499 thousand. The number of projects then fell again to 8.3% in the \$3 million to \$4.9 million budget interval and 8.3% received \$15 million and up. Only 4.2% of project received \$7 million to \$10.9 million.

Percent of project abstracts according to overall budget interval - comparison between conflict/post conflict and post natural disasters

Bar graph #2

As is illustrated in this graph, funding to projects addressing conflict/post conflict and post natural disaster situations is fairly even until the higher budget intervals. In the \$7 million to \$10.9 million budget interval, the majority of funding is given to conflict/post conflict projects while only post natural disaster projects are represented in the \$15 million and up interval.

CIDAs mental health budget

The first year in the period under analysis that mental health was addressed as a component in a project funded by CIDA was in 1997/1998. This year 0.5% of the overall budget was given to projects that contained a component of mental health and 7.4% of the health budget was allocated to projects that contained a component of mental health. The following year (1998/1999) the budget allocated to mental health experienced an increase, receiving 0.8% of the overall budget and 10.10% of the health budget. This pace was not sustained in subsequent years when in 1999/2000 mental health received 0.05% of the overall budget; and 0.5% of the health budget, in 2000/2001 mental health received 0.07% of the overall budget and 0.6% of the health budget. Although the overall budget

for mental health remained below 0.5% from 2001 to 2005, the health component of the budget started to increase steadily in the same time period with the exception of the 2003/2004 year. In 2001/2002, 3.7% of the health budget was devoted to projects with a component of mental health, in 2002/2003, 4% of the health budget was devoted to projects with a component of mental health. In 2003/2004, this 4% was reduced to 0.2% of the overall budget and 0.02% of the health budget. There was a significant increase in 2004/2005 where mental health received 1.34% of the overall budget and 7% of the health budget, but the percentages fell again in 2005/2006 when mental health received 0.1% of the overall budget and 0.9% of the health budget. The following chart presents these figures in graphic form.

MENTAL HEALTH BUDGET

<u>Year</u>	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001
Overall CIDA budget	\$1.5 billion	\$1.5 billion	\$1.5 billion	\$1.4 billion	\$1.5 billion	\$1.6 billion
Budget to projects w MH			\$7.5 million	\$11.5 million	\$817,000.00	\$1 million
% to mental health			0.50%	0.80%	0.05%	0.07%
CIDA health budget	\$97 million	\$66 million	\$102 million	\$106 million	\$160 million	\$210 million
Budget to projects w MH			\$7.5 million	\$11.5 million	\$817,000.00	\$1 million
% to mental health			7.40%	10.10%	0.50%	0.60%

<u>Year</u>	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Overall CIDA budget	\$1.8 billion	\$1.9 billion	\$2.2 billion	\$2.9 billion	\$2.7 billion	\$2.9 billion
Budget to projects w MH	\$9 million	\$10 million	\$524,933.63	\$39 million	\$3.5 million	\$550,000.00
% to mental health	0.50%	0.50%	0.02%	1.34%	0.10%	0.02%
CIDA health budget	\$264 million	\$252 million	\$301 million	\$573 million	\$380 million	\$519 million
Budget to projects w MH	\$9 million	\$10 million	\$524,933.63	\$39 million	\$3.5 million	\$550,000.00
% to mental health	3.70%	4%	0.20%	7.00%	0.90%	0.10%

Budget to projects w MH = Budget to projects with a component of mental health
% to mental health = percentage of budget given to projects with a component of mental health

*The "Overall CIDA budget" row represents CIDA's overall budget for that funding year. The "Budget to projects with MH" row represents the amount of the overall budget given to projects with a component of mental health for that funding year and the "% to mental health" row represents the percentage of the overall budget given to projects with a component of mental health for that funding year.

*The "CIDA health budget" row represents CIDA's health budget for that funding year. The "Budget to projects with MH" row represents the amount of the health budget given to projects with a component of mental health for that funding year and the "% to mental health" row represents the percentage of the health budget given to projects with a component of mental health for that funding year.

Open coding

Following the principles of grounded theory, I first applied open coding to the forty seven (47) CIDA project abstracts. The open coding, i.e, the choice of key descriptors (word/phrase) in the project abstracts, also referred to as 'nodes' in NVivo, results in grouping the key descriptors to create categories. Some nodes contributed to the creation of categories while others contributed to variables.²² Using NVivo terminology, I will refer to the number of abstracts as "sources" and to the frequency of occurrences of a word/descriptor/phrase within a category, variable or node as "references".

The 'categories', 'variables', and 'nodes' that arose from open coding include:

- **Variable: Region** (47 sources, 47 references), *nodes include:* Americas, Asia, Eastern Europe, North Africa and Middle East, Sub Saharan Africa²³
- **Variable: Type of funding** (47 sources, 47 references), *nodes include:* multilateral, bilateral, partnership
- **Variable: Budget** (47 sources, 47 references), up to 200,000.00, 200,000.00 to 499,000.00, 500,000.00 to 999,000.00, 1, 000,000.00 to 2,999,000.00, 3,000,000.00 to 4,999,000.00, 5,000,000.00 to 6,999,000.00, 7,000,000.00 to 10,999,000.00, 11,000,000.00 to 14,000,000.00, 15,000,000.00 and up.
- **Category: Culture and values** (15 sources, 37 references), *nodes include:* consideration of local culture, human rights, participatory process, peace building and conflict resolution, recuperation, re-establish, reparation and reconciliation and restore livelihoods.
- **Category: Human capacity** (47 sources, 184 references) *nodes include:* advocacy, awareness, capacity, child protection, coping mechanisms, counseling services, education, empowerment, express their experiences and reactions, knowledge building, mental health, mental health services, physical rehabilitation, play and education for children, psycho-therapeutic, PTSD, rehabilitation, skills, solutions to end violence, strengthen, support, training, trauma, workshops.

²² The 'variables' here refer to the 'categorical' variable of 'Region' and 'type of funding', and the 'interval' variable of budget.

²³ These regions were adopted for this study as they are the divisions of regions used by CIDA to guide programming decisions.

- **Category: Social ecology** (16 sources, 24 references), *nodes include*: community development, rebuilding (material reconstruction), rebuilding communities, reunification and reintegration, social reconstruction, sustainable support.
- **Category: Population targeted** (21 sources, 33 references), *nodes include*: age, communities, displaced persons, families, gender, girls and women, indigenous, poor, prisoners, survivors of conflict, survivors of natural disasters, victims of violence, workers.
- **Category: Location** (16 sources, 22 references), *nodes include*: child defence offices, education system, hospitals, resettlement camps, school system
- **Category: Explicit psychosocial**²⁴ (39 sources, 49 references)
- **Category: Explicit mental health**²⁵ (9 sources, 11, references)

²⁴ 'Explicit psychosocial' means in the context of this research that the word 'psychosocial' was used in the project abstract.

²⁵ 'Explicit mental health' means in the context of this research that the word 'mental health' was used in the project abstract

Summary of categories²⁶

Category	Sources	Ref ²⁷
Culture and values	15	37
Social Ecology	16	25
Human capacity	45	165
Location	16	22
Explicit mental health	9	11
Explicit psychosocial	39	49
Population targeted	21	33

Summary of variables

Variable	Sources	Ref
Region	47	47
Type of funding	47	47
Budget	47	47

Summary of nodes contributing to each category

Category	Sources	Ref
Culture and values	15	37
Nodes	Sources	Ref
Consideration of local culture	1	1
Human Rights	5	10
Participatory process	2	3
Peace building and conflict resolution	7	15
Recuperation	2	2
Re-establish	2	3
Reparation and reconciliation	2	2
Restore livelihoods	1	1
Category	Sources	Ref
Human capacity	45	195
Nodes	Sources	Ref
Advocacy (human capacity)	3	4
Awareness	5	5
Capacity	4	6
Child protection	13	22
Individual coping mechanisms	4	7
Counselling services	26	43

²⁶ The numbers in **bold font** indicate the highest frequency of references under each category or variable

²⁷ Number of references

Education	14	23
Empowerment	1	1
Express their experiences and reactions	1	1
Knowledge building	7	7
Physical rehabilitation	1	2
Play and education for children	12	18
Psycho-therapeutic	1	1
PTSD	1	2
Rehabilitation	6	9
Individual skill building	1	1
Solutions to end violence	2	2
Strengthen	6	7
Support	4	4
Training	10	24
Trauma	5	5
Workshops	1	1

Category	Sources	Ref
Location	16	24

Nodes	Sources	Ref
Child defence offices	1	3
Education system	4	4
Hospitals	2	2
Resettlement camps	4	4
School system	9	11

Category	Sources	Ref
Population targeted	21	300

Nodes	Sources	Ref
Children and youth	19	41
Communities	1	2
Displaced persons	5	8
Families	4	5
Gender	26	51
Girls and women	41	163
Indigenous	1	2
Poor	1	2
Prisoners	1	1
Survivors of conflict	7	9
Survivors of natural disasters	5	7
Victims of violence	3	3
Workers	6	6

Category	Sources	Ref
Social Ecology	16	26
Nodes	Sources	Ref
Community development	2	2
Rebuilding (material reconstruction)	4	4
Rebuilding communities	3	4
Reunification and reintegration	9	12
Social Reconstruction	1	1
Sustainable support	2	3
Category	Sources	Ref
Explicit psychosocial	39	49
Category	Sources	Ref
Explicit mental health	9	11

Summary of nodes contributing to each variable

Variable	Sources	Ref
Region	47	47
Nodes	Sources	Ref
Americas	8	8
Asia	20	20
Eastern Europe	6	6
North Africa and Middle East	5	5
Sub Saharan Africa	8	8
Variable	Sources	Ref
Type of funding	47	47
Nodes	Sources	Ref
Bilateral	11	11
Multilateral	26	26
Partnership	10	10
Variable	Sources	Ref
Budget	47	47
Nodes	Sources	Ref
Up to 200 thousand	11	11
200 to 499 thousand	6	6
500 to 999 thousand	10	10
1 to 2.9 million	9	9
3 to 4.9 million	2	2
5 to 6.9 million	2	2
7 to 10.9 million	5	5
11 to 14 million	0	0
15 million and up	2	2

Coding for categories

As explained in the methodology chapter, nodes contributed to the development of categories and variables. The following illustrates all the categories and variables coded for the project abstract titled: Facilitating Sustainable Community Development represented for its A) coding density (NVivo) and as a B) simple cluster of categories. The variables illustrated include: type of organization and region. The categories presented include: social ecology, human capacity, explicit psychosocial, location, and culture and values.

A) Example of Categories and Variables: CIDA project # A033365, Project title: Facilitating Sustainable Community Development

The screenshot displays the NVivo software interface. The main window shows the project abstract for 'A033365 Facilitating Sust. Community Development'. The abstract text describes a project in Pakistan aimed at reducing the impact of the South Asia Earthquake on children and their families through a sustainable program focused on rebuilding various aspects of the life communities, with an emphasis on basic education, child protection and psychosocial support. The proposed project will benefit 7,000 children and their families. The goal of the project is to re-establish child friendly communities in the Mansehra District. This will include the re-establishment of permanent, gender and disabled friendly schools. Plan will also be involved with government and local NGO partners to strengthen the quality of education for girls and boys. There will be increased awareness and participation on the part of communities in relation to child protection and education.

On the right side of the interface, a 'Coding Density' panel is visible, showing a hierarchical structure of categories and variables. The categories are listed as follows:

- Coding Density
 - Type of organization
 - Social Ecology
 - Region
 - Human capacity
 - Explicit psychosocial support
 - Location
 - Culture and values

*Coding density as seen on the far right hand side of this project abstract represents the density of all categories, variables and nodes coded in this one project abstract.

B) Example of Categories and Variables: CIDA project # A033365, Project title: Facilitating Sustainable Community Development

This visual represents the same project as above (as a simple cluster of categories) and all the categories and variables that have been coded in it. As is shown, the categories and variables include: culture and values, explicit psychosocial, region, human capacity, social ecology, type of organization and location.

Coding for nodes

As explained in the methodology, each category and variable consists of nodes. The following illustrates all the nodes coded in the project abstract titled: Facilitating Sustainable Community Development that contributed to the construction of the category, '*human capacity*'. These nodes include: child protection, awareness, strengthen, education, play and education for children.

Example of Nodes contributing to "human capacity": CIDA project # A033365, Project Title: Facilitating Sustainable Community Development

The screenshot displays a software window titled "PS - A033365 Facilitating Sustainable Community Development". The window has a menu bar with options: File, Edit, View, Project, Links, Code, Format, Tools, Window, and Help. The main text area contains the following information:

A033365 Facilitating Sust. Community Development
 2007-01-10 2008-08-29 \$1,500,000.00 \$550,000.00 A033365001 Facilitating Sust. Community Development Plan International
 Canada Inc. (Plan Canada)
 Pakistan The Facilitating Sust. Community Development in Siran Valley Mansehra District project will work to reduce the impact of the South Asia Earthquake on children and their families through a sustainable program focused on rebuilding various aspects of the life communities, with an emphasis on basic education, child protection and psychosocial support. The proposed project will benefit 7,000 children and their families. The goal of the project is to re-establish child friendly communities in the Mansehra District. This will include the re-establishment of permanent, gender and disabled friendly schools. Plan will also be involved with government and local NGO partners to strengthen the quality of education for girls and boys. There will be increased awareness and participation on the part of communities in relation to child protection and education.

On the right side of the window, there is a vertical bar labeled "Coding Density". Below this bar, a chart shows the density of coding for various nodes. The nodes and their corresponding density bars are:

- Child protection
- awareness
- Strengthen
- Education
- Play and education for children

Example of Categories, Variables and Nodes contributing to 'human capacity':
CIDA project # A033365, Project title: Facilitating Sustainable Community Development

This visual represents the same project abstract as above and the category and variables that have been coded in it. It also illustrates all the nodes that contribute to the category of '*human capacity*'. Each category and variable will have a different set of nodes that have contributed to them. As shown, the nodes contributing to the '*human capacity*' category include: play and education for children, strengthen, awareness, education, and child protection.

Queries

The queries I performed represent the co-occurrence of categories by cross referencing two nodes, a variable and a node, a category and a node, two categories and three categories. As described in Chapter II: Methodology, in content analysis this search for co-occurrences in the data represents a method of relational analysis. Relational analysis seeks to look for meaningful relationships and the queries I used were meant to derive meaning from the relationships found in the data, in this case within the forty seven (47) project abstracts and one PAD.

One of my significant findings was the discovery that the majority of projects were psychosocial in nature and therefore deemed it important to explore these relationships further. The Psychosocial Working Group (PSWG) offers a broad based analysis of psychosocial interventions that is supported by academics as well as NGO's in the field. In the end, my investigation revealed that the majority of projects could be defined, using the definition provided by the PSWG, as using psychosocial interventions to address mental health issues.

The following chart provides a list of queries I performed. It is organized into co-occurrences of two nodes, a variable and a node, a category and a node, two categories and three categories. I then created the subsections of queries for conflict/post conflict and post natural disaster for a more in depth analysis. Further analysis of these findings will be elaborated in the next section Chapter VI: Analysis.

SUMMARY OF QUERIES²⁸

Name	Sources	References
Co-occurrence of two nodes		
Children and Families	6	6
Children and youth	2	2
Girls and women with children	7	27
Children with boys and men	2	8
Children with girls and women	7	27
Boys and men with children	2	8
Co-occurrence of a variables and nodes		
Eastern Europe and children and youth	4	13
Eastern Europe and boys and men	0	0
Eastern Europe and girls and women	1	2
North Africa and boys and men	0	0
North Africa and Middle East and boys and men	0	0
North Africa and Middle East with children and youth	2	6
North Africa and the Middle East and girls and women	2	6
Sub Saharan Africa and boys and men	1	2
Sub Saharan Africa and girls and women	3	17
Sub Saharan Africa with children and youth	5	23
Americas and girls and women	2	11
Americas and men and boys	1	3
Americas with children and youth	2	4
Americas with children and youth	2	4
Africa and the Middle East and girls and women	2	9
Asia and girls and women	9	21
Asia and men and boys	3	7
Asia with children and youth	3	8
Bilateral and up to 200,000	1	1
Bilateral and up to 200,000 to 499,000	0	0
Bilateral and 500,000 to 999,000	2	2
Bilateral and 1,000,000 to 2,999,000	3	3
Bilateral and 3,000,000 to 4,999,000	1	1
Bilateral and 5,000,000 to 6,999,000	2	2
Bilateral and 7,000,000 to 10,999,000	1	1
Bilateral and 11,000,000 to 14,000,000	0	0

²⁸ The numbers in bold indicate the queries explored in Chapter VI: Analysis

Bilateral and 15,000,000.00 and up	1	1
Multilateral up to 200,000	5	5
Multilateral and 200,000 to 499,000	6	6
Multilateral and 500,000 to 999,000	7	7
Multilateral and 1,000,000 to 2,999,000	6	6
Multilateral and 3,000,000 to 4,999,000	1	1
Multilateral and 5,000,000 to 6,999,000	0	0
Multilateral and 7,000,000 to 10,999,000	0	0
Multilateral and 11,000,000 to 14,000,000	0	0
Multilateral and 15,000,000 and up	1	1
Partnership and up to 200,000	5	5
Partnership and 200,000 to 499,000	0	0
Partnership and 500,000 to 999,000	1	1
Partnership and 1,000,000 to 2,999,000	0	0
Partnership and 3,000,000 to 4,999,000	0	0
Partnership and 5,000,000 to 6,999,000	0	0
Partnership and 7,000,000 to 10,999,000	4	4
Partnership and 11,000,000 to 14,000,000	0	0
Partnership and 15,000,000 and up	0	0
Co-occurrence of categories and nodes		
Children with human capacity	19	115
Children with culture and values	8	38
Children with explicit psychosocial	17	52
Children with social ecology	10	39
Boys and men with culture and values	2	7
Boys and men with human capacity	2	7
Boys and men with explicit psychosocial	3	24
Boys and men with explicit mental health	1	3
Boys and men with social ecology	2	9
Girls and women and culture and values	11	51
Girls and women and human capacity	17	110
Girls and women and explicit psychosocial	16	48
Girls and women and explicit mental health	4	10
Girls and women and social ecology	9	28
Americas and culture and values	3	14
Americas and human capacity	8	33
Americas and explicit psychosocial	5	13
Americas and social ecology	1	3
Americas and explicit mental health	4	8
Asia and culture and values	7	19
Asia and human capacity	16	63
Asia and explicit psychosocial	16	37

Asia and social ecology	8	20
Asia and explicit mental health	3	7
Eastern Europe and culture and values	0	0
Eastern Europe and human capacity	6	21
Eastern Europe and explicit psychosocial	4	9
Eastern Europe and explicit mental health	0	0
Eastern Europe and social ecology	0	0
North Africa and Middle East and culture and values	2	7
North Africa and Middle East and human capacity	5	31
North Africa and Middle East and social ecology	1	2
North Africa and Middle East and explicit psychosocial	4	8
North Africa and Middle East and explicit mental health	2	5
Sub Saharan Africa and culture and values	3	22
Sub Saharan Africa and human capacity	6	58
Sub Saharan Africa and explicit psychosocial	6	25
Sub Saharan Africa and explicit mental health	0	0
Sub Saharan Africa and social ecology	4	21
Culture and values and bilateral	6	22
Culture and values and multilateral	4	9
Culture and values and partnership	5	20
Human capacity and bilateral	10	68
Human capacity and multilateral	23	76
Human capacity and partnership	9	54
Social ecology and bilateral	6	17
Social ecology and multilateral	5	10
Social ecology and partnership	5	14
Co-occurrence of two categories		
Culture and values with human capacity	15	113
Human capacity with social ecology	16	106
Culture and values with social ecology	11	43
Co-occurrence of three categories		
Culture and values with human capacity and social ecology	15	125
Conflict/Post Conflict subgroup		
Social ecology, culture and values, and human capacity	3	13
Culture and values and social ecology	6	28
Human capacity and social ecology	9	78
Culture and values and human capacity	9	86
Girls and women	10	39
Boys and men	0	0
Explicit psychosocial	21	28

Explicit mental health	4	5
Post Natural Disaster subgroup		
Social ecology, culture and values, and human capacity	2	5
Culture and values and social ecology	5	15
Human capacity and social ecology	7	28
Culture and values and human capacity	6	27
Girls and women	10	17
Boys and men	0	0
Explicit psychosocial	18	21
Explicit mental health	5	6

Conclusion

This chapter reviewed the distribution of project abstracts according to region and offered a comparison of the distribution between conflict/post conflict and post natural disaster situations. The amount of funding given to projects addressing conflict/post conflict and post natural disaster situations was also presented. Next, the percentage of funding given to mental health as compared to CIDAs overall budget and CIDAs health budget for each funding year was represented. Next, the open coding of the categories of 'culture and values', 'human capacity', , 'location', 'population targeted' 'social ecology', 'explicit psychosocial' and 'explicit mental health' as well as the nodes contributing to them were presented. The results of the open coding which included the variables of 'Region', 'Type of funding' and 'Budget' and the nodes contributing to them were presented. Furthermore, a visual illustration of the coding of the categories and the nodes contributing to the 'human capacity' category for one project abstract was shown. Finally, a summary of the queries performed is presented. Chapter VI: Analysis provides an analysis by region, budget, type of funding and specific queries. An in depth analysis will address the queries performed.

Chapter VI: Analysis

Introduction

This section analyzes the results by region, budget, type of funding and specified queries. For the purpose of this analysis, region, budget and type of funding are referred to as variables. The regions are Asia, Eastern Europe, Americas, North Africa and the Middle East, and Sub Saharan Africa. The budgets range from; up to \$200 thousand, \$200 thousand to \$499 thousand, \$500 thousand to \$999 thousand, \$1 million to \$2.9 million, \$3 million to \$4.9 million, \$5 million to \$6.9 million, \$7 million to \$10.9 million, \$11 million to \$14 million, and \$15 million and up. The multilateral, bilateral and partnership branches of CIDA constitute the 'type of funding' variable.

Additionally, I will present an analysis of the queries²⁹ (the frequencies of the co-occurrence of categories, variables and nodes)³⁰ that arose from cross referencing two nodes, a variable and a node, a category and a node, two categories, and three categories. A careful examination of these frequencies provided the bases for the creation of an arbitrary threshold for significant relationships. The significant relationship in the data for any of the levels of cross referencing was a frequency of twelve (12) out of forty seven (47) (25% of the project abstracts) or more sources. In addition, non significant relationships in the data defined as a frequency of zero or one were analyzed. Lastly, I will present a comparative analysis of queries between project abstracts addressing post natural disasters and those addressing conflict/post conflict situations. The level of significance used for the analysis of the forty seven (47) project abstracts (established at 25%) was maintained to determine levels of significance within specific co-occurrences.

²⁹ See Chapter IV: Methodology, p. 85 for a full list of queries.

³⁰ In this study nodes contribute to both categories and variables, see also pages 77-79 in Chapter V: Results.

Analysis by regions

In the 'region' variable, there are clear differences between the distribution of project abstracts addressing post natural disaster (23 project abstracts) and conflict/post conflict situations (24 project abstracts). The 'Asia' region is prominent in project abstracts addressing post natural disaster situations. Overall, eighteen (18) out of the forty seven (47) project abstracts (38% of project abstracts overall) address countries situated in the 'Asia' region. Seventeen (17) of the eighteen (18) project abstracts in the 'Asia' region address post natural disaster situations. Therefore, as there are twenty three (23) project abstracts that address post natural disaster situations, seventeen (17) of these twenty three (23) (74% of post natural disaster project abstracts) address countries situated in the 'Asia' region. This is likely a result of CIDA's response to the South and South East Asian tsunami in late 2004. Furthermore, there are regions in Asia such as Pakistan and surrounding areas that are prone to earthquakes. These other disaster prone areas likely contribute to the large number of agencies CIDA supports in the region.

Under the 'region' variable of the post natural disaster group, the 'Americas' was referenced the second most frequently. There were five (5) projects (22% of post natural disaster project abstracts) devoted to the region. It is not surprising that the 'Americas' region was second in this category as the region is prone to natural disasters such as earthquakes and hurricanes. However, the 'Americas' did not experience a disaster on the same scale as the tsunami of 2004 in South and South East Asia and as a result did not receive the same amount of attention or funding for projects. The 2004 tsunami in South and South East Asia received ongoing and extensive public attention because it occurred on Christmas Eve and because of the severity of the event, the high number of casualties

and the extensive media coverage. These factors may have led CIDA to devote money to numerous organizations seeking funding to run projects in the affected area. On the other hand, although natural disasters in the 'Americas' region are numerous, fewer people are affected, and the disasters do not receive the same level of publicity as the South and South East Asian tsunami of 2004.

The distribution of project abstracts in the regions is quite different when examining project abstracts that address conflict/post conflict situations. In this category, the distribution among three of the regions is even. Of the twenty four (24) project abstracts that addressed conflict/post conflict situations, CIDA has funded six (6) projects in 'Sub Saharan Africa' (25% of conflict/post conflict project abstracts), five (5) in 'North Africa and the Middle East' (20% of conflict/post conflict project abstracts) and five (5) in 'Eastern Europe' (20% of conflict/post conflict project abstracts). Other regions funded include three (3) projects in the 'Americas' (12.5% of conflict/post conflict project abstracts) and only one (1) in 'Asia' (4.2% of conflict/post conflict project abstracts).

Funding provided by CIDA reflects current world events. This is made clear by the distribution of project abstracts that address each of the specific regions. CIDA is Canada's aid agency and is an integral part of the international community. Therefore, the breakdown of regions could be an indication of what is deemed as important to address by the international community. One example of this is the large number of project abstracts that addressed the countries affected by the South and South Asian tsunami of 2004. The public interest in this event was high and other international organizations were also devoting a substantial amount of time and money in the aftermath.

Analysis by budget

This section will address the amount of funding given to mental health in comparison to CIDA's overall budget as well as CIDA's health budget. It will also address the changes and fluctuations that have occurred over the years. Seventy six percent (76% of project abstracts overall) or thirty six (36) out of the forty seven (47) projects included in this study received funding between \$200 thousand and \$2.9 million. The remaining eleven (11) projects received between \$3million and \$15million. This is an important finding because it indicates the amount of funding is relatively low and provides evidence that the value placed on mental health interventions overall within CIDA³¹ is not major.

Within the health budget, the funding given to projects that address mental health issues is low with the highest percentage devoted to mental health being in the year 2004/2005. A large amount of funding to address issues associated with the tsunami was provided in 2004/2005 and as a result, represents the highest percentage of funding for projects with a component of mental health.

Global interests and publications from international authorities on health and development have also affected the percentage of funding that CIDA provides for projects with a component of mental health. As mentioned in Chapter II: Theoretical Framework, *The Action Plan on Health and Nutrition 2001* was the first CIDA document to acknowledge mental health issues as an important contributor to the global burden of disease. This plan may have affected the support CIDA provided to mental health. For two consecutive years following the declaration of *CIDA's Action Plan on Health and Nutrition 2001* the relative amount of funding for projects addressing mental health issues

³¹ Please see chart on page 74 in Chapter V: Results representing funding given to mental health as a percentage of CIDA's overall budget and as a percentage of CIDA's health budget.

rose. In 2000/2001, 0.6% of the health budget was dedicated to projects with a component of mental health while in 2001/2002, it rose to 3.7% and in 2002/2003 it rose again to 4%. Additionally, during the year of the South and South East Asian tsunami in 2004/2005, funding for projects containing a component of mental health rose to 7% of the health budget. Furthermore, projects that contained a component of mental health within the scope of the data analyzed for this thesis (1995 – present) were not recorded until after the publication of two key documents: *World mental health: problems and priorities in low income countries* (Desjarlais, et al., 1995), and *The global burden of disease* (WHO, 1996). Additionally, *CIDA's Action Plan on Health and Nutrition 2001* was influenced by *the World Mental Health Report 2001* (WHO, 2001a). Health programming in CIDA can therefore be said to be influenced by developments in the field of mental health in international development.

Analysis by type of funding

There are some differences in the distribution of funding among the three funding branches in CIDA. As stated previously in Chapter II: Theoretical Framework, multilateral agencies are supported financially by many countries and “help set the rules for the governance of the world economy and in areas such as health, agriculture, human rights, peace and security and humanitarian assistance” (CIDA, 2007b). Examples of multilateral agencies that CIDA has funded that contained a component of mental health are the UN Agencies such as UNICEF, the Pan American Health Organization (PAHO) and the World Health Organization (WHO) as well as the International Federation of Red Cross/Red Crescent Societies. In the multilateral branch the largest numbers of projects

(7) were funded in the \$500 thousand to \$999 thousand budget interval, while very few were funded in the other budget intervals.

In CIDA, bilateral aid is given from CIDA directly to another government in need of assistance. In contrast to the multilateral distribution, in the bilateral branch the number of projects was more evenly distributed. The largest number of projects given to one budget interval in the bilateral branch was three (3) in the \$1 million to \$2.9 million budget interval.

The partnership branch encourages Canadian private and voluntary sector organizations such as “non-governmental organizations, educational institutions, professional memberships and associations, cooperatives, youth organizations, and companies” (CIDA, 2007c) to contribute to international cooperation initiatives. In the partnership branch, the majority of the projects funded appeared in two budget intervals. Five (5) projects were funded in the up to \$200 thousand budget interval and four (4) projects funded in the \$7 million to \$10.9 million budget interval.

Although none of the results were significant when cross referencing the nodes included in the ‘type of funding’ variable with the ‘budget’ intervals, significance was found when cross referencing the ‘type of funding’ variable with numerous different nodes. These will be discussed in the *Analysis of queries* section of this chapter.

Analysis of queries

The queries executed in NVivo represent the co-occurrence of categories, variables and nodes by cross referencing two nodes, nodes and sub-regions³², categories

³² Within the variable ‘Region’ the ‘sub-regions’ include: Asia, Americas, Eastern Europe, North Africa and the Middle East, and Sub Saharan Africa.

and type of funding³³, categories and sub-regions, categories and nodes, two categories, and three categories. The cross referencing of two nodes did not produce any significant relationships, therefore this section will be organized as follows: co-occurrence of nodes and sub-regions, co-occurrence of categories and type of funding, co-occurrence of categories and sub-regions, co-occurrence of categories and nodes, co-occurrence of two categories, and the co-occurrence of three categories . The discussion will focus on significant relationships with a frequency of 12 sources (25% of project abstracts) and non-significant relationships (frequency of zero or one sources) discovered during the cross referencing process.

Co-occurrence of nodes and sub-regions

The first step was to cross reference the co-occurrence of a node and a sub-region. Cross referencing the 'girls and women' node (which contributed to the 'population targeted' category) with the 'Eastern European' sub-region (which contributed to the 'region' variable) did not produce a significant relationship. One project abstract (2% of project abstracts overall) contained at least one reference in the 'girls or women' node *and* at least one reference in the 'Eastern European' sub-region.³⁴ Within the 'region' variable, there are six (6) project abstracts included in the 'Eastern European' sub-region. Therefore, 16% of projects in this region mention girls or women (1 of 6 project abstracts

³³ Within the variable of 'Type of funding' the types include: multilateral, bilateral and partnership.

³⁴ Even though some nodes, categories or variables in each specific query may include more than one reference, for the purposes of this study, one reference was considered sufficient to qualify for co-occurrence. Given the significant amount of cross referencing required in order to analyse the data, it was judged that it was not necessary to add another level of complexity by considering the number of references within the nodes, categories, and variables. The methodology used provided a rich analysis.

refer to girls or women), which is not a significant relationship in this co-occurrence. The programs running in the 'Eastern Europe' region:

focus primarily on good governance, democratic development, and economic well-being. Particular emphasis is given to improving the accountability, transparency, and effectiveness of state institutions; supporting civil society; and creating a more favourable business and investment climate throughout the region (CIDA, 2007d).

It is clear from this quote that gender is not a high priority in the region of Eastern Europe. Because CIDA's focus in this region is to provide funding to agencies that address issues of "good governance" and "economic well being", it is unlikely that mental health interventions in this region are a high priority. The combination of the lack of attention to mental health and the lack of attention to gender (girls and women) in the region has produced the non significant relationship.

When the 'boys and men' node (which contributed to the 'population targeted' category) was cross referenced with the 'Sub Saharan Africa' sub-region (which contributed to the 'region' variable), it did not represent a significant relationship. One project abstract (2% of project abstracts overall) contained a minimum of one reference coded in the 'boys or men' node *and* at least one reference in the 'Sub Saharan Africa' node. Gender equality is a central theme in CIDA's mandate for the 'Sub Saharan Africa' region but the data indicates that very few projects address boys and men specifically. Similar findings were found in the 'Americas' region where one project abstract (2% of project abstracts overall) contained a minimum of one reference coded in the 'Americas' sub-region *and* at least one reference coded in the 'boys or men' node. At the same time, the data revealed that overall, forty one (41) of the forty seven (47) project abstracts mention women (87% of project abstracts overall).

These are significant findings and could be a result of ‘gender equality’ being equated with a focus on empowering women internationally. This is an indication that CIDA is following the international trend in understanding ‘gender equality’ as primarily a women’s issue (Hanmer & Naschold, 2000). The data would indicate that the mental health of boys and men is being largely ignored as a result of the strong international focus on girls and women as a method to promote gender equality.

Co-occurrence of categories and sub-region

Forty five (45) of the project abstracts contained a reference in the category of ‘human capacity’³⁵ while eighteen (18) of the forty seven (47) project abstracts were referenced in the ‘Asia’ sub-region. It is therefore not surprising that when cross referencing ‘Asia’ and ‘human capacity’, it yielded a significant relationship. The cross reference produced sixteen (16) project abstracts (35% of project abstracts overall) that addressed countries in the ‘Asia’ sub-region *and* had at least one reference in the category of ‘human capacity’. This data indicates that sixteen (16) of the eighteen (18) projects funded in the ‘Asia’ sub-region had a reference to the ‘human capacity’ category.

There was also a significant relationship when the ‘Asia’ sub-region was cross referenced with the category of ‘explicit psychosocial’. This cross reference indicated that there were sixteen (16) project abstracts (34% of project abstracts overall) with at least one reference to ‘Asia’ and ‘explicit psychosocial’. As was described in ‘Chapter III: Literature Review’ development organizations such as the Interagency Standing Committee (2007), the International Federation of Red Cross/Red Crescent (2003), the

³⁵ Reminder to the reader: Human capacity includes the physical and mental health of a person as well as his or her knowledge and skills (PSWG, 2003a).

Psychosocial Working Group (2003) and the International Organization for Migration (2000) support psychosocial interventions as the most useful mental health interventions in conflict/post conflict and post natural disaster situations. This data therefore reflects CIDA adopting best practices for addressing mental health concerns in conflict/post conflict and post natural disaster situations in the 'Asia' sub-region.

One possible explanation for the significantly high number of projects in 'Asia' that also contain a reference in 'human capacity' and 'explicit psychosocial', is the large number of projects in the Asia region. As mentioned previously in this chapter, this is a result of the 2004 South and South East Asian tsunami as well as other natural disasters in the Asian region. These tragic events combined with CIDA's focus on 'human capacity' and 'explicit psychosocial' created a significant relationship when cross referenced.

Upon cross referencing the 'North Africa and the Middle East' sub-region with the category of 'social ecology',³⁶ it did not appear as a significant relationship. One project abstract (2 % of project abstracts overall) contained a minimum of one reference in the 'social ecology' category *and* at least one reference in the 'North Africa and the Middle East' sub-region. There were five (5) projects included in the 'North Africa and the Middle East' sub-region. Therefore, one (1) project abstract that contained a reference in the 'social ecology' category represents 20% of those within the region. Within this co-occurrence, when maintaining a frequency of 25% as the level of significance for analysis, the result of 20% does not represent a significant relationship.

As was the case with 'North Africa and the Middle East', when cross referencing the 'Americas' sub-region with the 'social ecology' category, it did not represent a

³⁶ Reminder to the reader: Social ecology refers to the social connections and support that people share and that form an important part of psychosocial well being (PSWG, 2003a).

significant relationship. One (1) project abstract (2 % of project abstracts overall) contained a minimum of one reference in the 'social ecology' category *and* at least one reference in the 'Americas' sub-region. There were eight (8) projects coded in the 'Americas' sub-region so one project abstract that contained a reference in the 'social ecology' category represents 12.5% of those within the region, which is not a significant relationship within this co-occurrence.

In order to analyze the non significant relationships between the 'social ecology' category and both the 'North Africa and the Middle East' and 'Americas' sub-regions, the researcher must address the common factor of 'social ecology'. As indicated in Chapter III: Literature Review, social ecology can be defined as "the social connections and support that people share and that form an important part of psychosocial well-being" (PSWG, 2003a). The definition of psychosocial provided by HealthNet-TPO (Transcultural Psychosocial Organization) places the "emphasis on reconnecting with their ordinary support systems to cope with any initial trauma" (HealthNet-TPO, 2007). Their focus on social support and connections emphasizes the concept of social ecology. The lack of focus on 'social ecology' in the project abstracts in 'North Africa and the Middle East' as well as the 'Americas' could indicate a lack of effort by CIDA to fund organizations that help to create social connections and attempt to re-establish former support systems. Another possible explanation is a lack of organizations approaching CIDA for funding that address issues of 'social ecology' in these two regions.

Co-occurrence of categories and type of funding

When cross referencing a category with the ‘type of funding’ variable, a significant relationship occurred between the ‘human capacity’ category and the ‘multilateral’ node (which contributed to the ‘type of funding’ variable). There were twenty three (23) project abstracts (49% of project abstracts overall) that contained at least one reference in the ‘human capacity’ category *and* at least one reference in the ‘multilateral’ node.

Multilateral agencies receive funding from many different organizations/agencies worldwide. They therefore have the financial capacity and available human resources to address critical situations quickly, whether they are conflict/post conflict or post natural disasters. The project abstracts analyzed focus on conflict/post conflict and post natural disaster situations and as a result many required swift responses. The nature of the projects under analysis and the capacity of the multilateral branch to address conflict/post conflict and post natural disaster situations quickly could explain why the projects that received funding from the multilateral branch represented approximately 50% of all project abstracts in this study. The high number of nodes contributing to the ‘human capacity’ category overall (45 out of the 47 project abstracts) and the high percentage of projects funded by the multilateral branch explains the significant relationship (49% of project abstracts overall) when cross referencing ‘human capacity’ and the ‘multilateral’ node.

An interesting comparison appears when using the ‘multilateral’ node as one subsection and the ‘bilateral and partnership’ nodes as another. Within the project abstracts analyzed, twenty six (26) projects received funding through the multilateral

branch. The twenty one (21) remaining projects were funded by CIDA through the bilateral branch (11 project abstracts) and the partnership branch (10 project abstracts). The 'multilateral', 'bilateral' and 'partnership' nodes all contribute to the 'type of funding' variable.

There are distinct differences between the type of funding provided by CIDA through the multilateral, bilateral and partnership branches. Projects undertaken by multilateral agencies for which CIDA provides funding are generally loans. The exceptions are some UN Agencies to which CIDA provides grants as well. Usually, CIDA's contribution is a small percentage (3-5%) of overall funds being used by multilateral agencies. CIDA has a limited amount of influence and involvement in multilateral programs as the development banks (ex. InterAmerican Development Bank, Asian Development Bank, African Development Bank) and the UN system pool CIDA's funds with those of many other donors. CIDA sits on the Boards of these organizations and can influence policy in consort with other like-minded donors.

Projects funded through the bilateral and partnership branches differ from those funded through the multilateral branch. Firstly, projects that receive funding from the bilateral and partnership branches receive grants and not loans. Furthermore, CIDA is the primary funder for bilateral and partnership projects and as a result have more control over the direction of the funds. The similarities between the bilateral and partnership branches and their differences to the multilateral branch mean it is appropriate to create two subcategories for comparison, one containing the multilateral node and the other containing the bilateral and partnership nodes.

When the 'multilateral' node was cross referenced with the 'human capacity' category it represented quite a significant relationship. Twenty three (23) of the twenty six (26) project abstracts (88%) in the 'multilateral' node contained a minimum of one reference in the 'human capacity' category *and* at least one reference in the 'multilateral' node. On the other hand, when the 'multilateral' node was cross referenced with the 'culture and values'³⁷ and 'social ecology' categories, the results were not significant.

When combining the 'bilateral' and 'partnership' nodes, there was a total of twenty one (21) project abstracts. All the relationships were significant when the 'bilateral' and 'partnership' nodes were cross referenced with the categories of 'culture and values', 'social ecology' and 'human capacity'. When cross referencing the 'culture and values' category with the 'bilateral' and 'partnership' nodes there were eleven (11) project abstracts (52 % of project abstracts in the bilateral and partnership nodes) that contained at least one reference in the 'bilateral' or 'partnership' nodes *and* at least reference in the 'culture and values' category. All of the project abstracts (100% of project abstracts in the bilateral and partnership nodes) contained at least one reference in the 'bilateral' or 'partnership' nodes *and* at least one reference in the 'human capacity' category. When cross referencing the 'social ecology' category with the 'bilateral' and 'partnership' nodes there were eleven (11) project abstracts (52% of project abstracts in the bilateral and partnership nodes) that contained at least one reference in the 'bilateral' and 'partnership' nodes *and* at least one reference in the 'social ecology' category.

³⁷ Reminder to reader: Culture and values points to the specific context and culture of communities that influence how people experience, understand and respond to events. (PSWG, 2003a)

These findings demonstrate that the multilateral branch has focused on funding projects that address 'human capacity' as opposed to 'social ecology' and 'culture and values'. This could indicate that international standards laid out by the United Nations, which are followed by multilateral agencies, focus heavily on human capacity issues. If multilateral agencies are addressing issues associated with 'human capacity', it provides space for other agencies to address issues associated with 'social ecology' and 'culture and values'. This could explain why all cross references between 'human capacity', 'social ecology' and 'culture and values' were significant in the subsection that included the 'bilateral' and 'partnership' branches.

Specifically, while the 'multilateral' node did not yield any significant relationships when cross referenced with 'culture and values' and 'social ecology', the 'bilateral' and 'partnership' nodes produced a high significance (52% of project abstracts in the bilateral and partnership nodes) when cross referenced with 'culture and values' and 'social ecology'. CIDA has a limited amount of control and contributes only a small percentage to projects undertaken through the multilateral branch. On the other hand, because CIDA has almost complete control over project activities and funding to projects in the bilateral and partnership branches, the projects funded through these branches are good representations of CIDA's values in addressing mental health issues.

Co-occurrence of categories and nodes

The next step in the analytic process was to cross reference one category and one node (which contributed to a category rather than to a variable) in order to determine their co-occurrence. The majority of project abstracts, forty one (41) of the forty seven (47)

(87% of the project abstracts overall), mention girls or women. This could be indicative of a link to CIDA's mandate of promoting gender equality and empowering women as indicated in the Millennium Development Goals (MDGs).³⁸ As an integral part of development assistance worldwide, CIDA has committed to attempt to fulfill this goal by 2015. Although a large majority of the project abstracts that reference girls or women does not clearly indicate that efforts are being made to empower girls and women, it does demonstrate an attempt to address the needs of girls and women.

Not surprisingly, as a large percentage of nodes contributed to the 'human capacity' category, when the 'girls and women' node (which contributed to the 'population targeted' category) was cross referenced with the category of 'human capacity', there was a significant relationship. Seventeen (17) project abstracts (36% of project abstracts overall) contained a minimum of one reference in the 'human capacity' category *and* at least one reference in the 'girls and women' node. As indicated by the data, the majority of references that contribute to the 'human capacity' category aim to increase the knowledge and skills of the population. The significant relationship that arose when cross referencing 'girls and women' with 'human capacity' demonstrates that CIDA has chosen to attempt to empower girls and women through 'human capacity' interventions that address "the physical and mental health of a person, as well as his or her knowledge and skills" (PSWG, 2003a).

Two significant relationships occurred when using the 'children' node (which contributed to the 'population targeted' category), as a cross reference. Firstly, the 'human capacity' category was cross referenced with the 'children' node. Eighteen (18) project

³⁸ Please refer to the Chapter II: Theoretical Framework, page 9 for a complete list of MDGs.

abstracts (38 % of project abstracts overall) contained a minimum of one reference in the 'human capacity' category *and* at least one reference in the 'children' node. Secondly, when cross referencing the 'children' node with the category of 'explicit psychosocial', it represented a significant relationship. There were seventeen (17) project abstracts (36% of project abstracts overall) that contained at least one reference in the 'children' node *and* at least one reference in the 'explicit psychosocial' category. The conclusion that can be drawn is that when addressing the needs of children, CIDA tends to support 'human capacity' and 'explicit psychosocial' initiatives.

One last significant relationship between categories and nodes appeared when using the category of 'explicit psychosocial' as a cross reference with the 'girls and women' node. This cross reference yielded sixteen (16) project abstracts (34% of project abstracts overall) with at least one reference in the category of 'explicit psychosocial' *and* at least one reference in the 'girls and women' node. In contrast, there were no significant relationships when the 'explicit mental health'³⁹ category was cross referenced with any node. These data indicate that a large percentage of the projects in this study that address 'children' and 'girls and women', specify psychosocial interventions as the preferred mental health intervention.

Co-occurrence of two categories

The next phase of queries involved the cross referencing of two categories, therefore representing their co-occurrence. A significant relationship was discovered when cross referencing the categories of 'culture and values' and 'human capacity'.

³⁹ Reminder to reader: 'Explicit mental health' means in the context of this research that the word mental health was used in the abstract.

Fifteen (15) project abstracts (32% of project abstracts overall) contained a minimum of one reference in each of the categories of 'culture and values' and 'human capacity'.

When cross referencing the 'social ecology' category and the 'human capacity' category, there was also a significant relationship. In this case there were sixteen (16) project abstracts (34% of project abstracts overall) that contained a minimum of one reference in each category.

These are relevant findings to the demonstration of my hypothesis⁴⁰ because they indicate a significant number of projects addressed two of the three categories involved in the definition of psychosocial. Both of the above queries involve 'human capacity' and either 'social ecology' or 'culture and values'. Many of the nodes that contributed to the development of the 'human capacity' category focus primarily on the individual.⁴¹ Some examples of nodes contributing to 'human capacity' include; PTSD (post traumatic stress disorder), individual coping mechanisms, individual skill building and expressing their experiences and reactions. CIDA's interventions in the categories of 'social ecology' (the social connections and support that people share) and 'culture and values' (the culture of the community and how that influences how people experience, understand and respond to events) focus on the relationships between people which is indicated by the nodes contributing to those categories.⁴² Some examples of nodes contributing to the two categories include; participatory process, community development and rebuilding communities.

⁴⁰ See Chapter I: Introduction, p.6

⁴¹ See Chapter 4: Methodology, p. 77 for a list of specific nodes contributing to the category of 'human capacity'.

⁴² See Chapter 4: Methodology, p.79 for a list of specific nodes contributing to the categories of 'social ecology' and 'culture and values'.

The significance of these queries therefore demonstrates a strong focus on the interaction between the psycho (individual) and social (relations between people) within CIDA funded projects. This focus is supported by other international development agencies as is represented in Chapter II: Theoretical Framework and Chapter III: Literature Review. For example, the definition of psychosocial given by the International Federation of Red Cross/Red Crescent Societies is to acknowledge psychosocial as the intersection between individual emotional reactions (psycho) and the relations between people (social) (IFRC, 2004), and the WHO suggest treating the individual while strengthening the capacity of the community.

As stated previously in this chapter, forty five (45) out of forty seven (47) project abstracts contained a node that contributed to the category of 'human capacity'. The number of project abstracts containing nodes that contributed to the 'social ecology' category (16) and the 'culture and values' category (15) were far fewer. The significance of the queries of 'culture and values' with 'human capacity' and 'social ecology' with 'human capacity' could be partially attributed to the high number of project abstracts containing references in the category of 'human capacity'.

Co-occurrence of three categories

The three categories of 'human capacity', 'social ecology' and 'culture and values' represent a significant relationship when cross referenced. In other words, fifteen (15) project abstracts (32% of project abstracts overall) contained a minimum of one reference in each category of 'human capacity', 'social ecology' and 'culture and values'. As is represented in 'Chapter II: Theoretical Framework', psychosocial is defined by the

Psychosocial Working Group (PSWG), as the interaction of the three categories of human capacity, social ecology and culture and values. The significance of this query is therefore indicative of the attempts that CIDA is making to take a psychosocial approach to mental health interventions as defined by international documents as outlined in Chapter III:

Literature Review.

Comparison between abstracts addressing conflict/post conflict and post natural disasters

In order to provide a more in depth analysis, a comparison of coding between project abstracts addressing conflict/post conflict situations and project abstracts addressing post natural disaster situations was conducted. This provided further insight into the similarities and differences of mental health interventions funded by CIDA between the two situations. In order to address the same issues that arose in the analysis of all the project abstracts combined, the separate analysis of the project abstracts will focus on the psychosocial categories of 'human capacity', 'social ecology' and 'culture and values' as well as the 'explicit psychosocial' and 'explicit mental health' categories. Additionally, the frequency of references included in the 'girls and women' and the 'boys and men' nodes will be queried.

A comparison of single item searches (a search for one term and not the co-occurrence of two or more terms) between project abstracts addressing conflict/post conflict and those addressing post natural disasters revealed that numerous searches were significant in both. In the project abstracts addressing post natural disaster situations, significant findings occurred when 'girls and women' (43% of project abstracts addressing post natural disasters) and 'explicit psychosocial' were searched (78% of

project abstracts addressing post natural disasters). The searches of 'boys and men' (0% of project abstracts addressing post natural disasters) and 'explicit mental health' (22% of project abstracts addressing post natural disasters) were not significant.

When conducting searches on the project abstracts addressing conflict/post conflict situations, significant relationships occurred when 'girls and women' (42% of project abstracts addressing conflict/post conflict) and 'explicit psychosocial' were searched (87% of project abstracts addressing conflict/post conflict). Similar to the project abstracts addressing post natural disasters situations, the searches of 'boys and men' (0% of abstracts addressing conflict/post conflict) and 'explicit mental health' (16% of abstracts addressing conflict/post conflict) were not significant.

The percentage of project abstracts in each subsection that contained a reference to the 'girls and women' node (43% for project abstracts addressing post natural disaster and 42% for project abstracts addressing conflict/post conflict) is approximately the same for each subsection. This is consistent with the finding of the significance of the same query performed on all the project abstracts. It demonstrates that CIDA is addressing the needs of girls and women by funding agencies that address the issue equally in both post natural disaster situations and conflict/post conflict situations. Furthermore, the search of 'boys and men' was not significant in either of the subsections. This is also consistent with the findings presented by the data that included all the project abstracts. This demonstrates the lack of focus on boys and men in the agencies that CIDA is funding in both the subsections of post natural disaster and conflict/post conflict situations.

Project abstracts that addressed post natural disasters represented significant relationships in the cross referencing of the categories of 'culture and values' and 'human

capacity' (26% of project abstracts addressing post natural disasters) and the categories of 'human capacity' and 'social ecology' (30% of project abstracts addressing post natural disasters). The non-significant relationships included the cross reference of 'social ecology', 'culture and values' and 'human capacity' (9% of project abstracts addressing natural disasters) and the cross reference of the categories of 'culture and values' and 'social ecology' (22% of project abstracts addressing natural disasters).

In project abstracts addressing conflict/post conflict situations, the significant relationships occurred when cross referencing the categories of 'culture and values' and 'human capacity' (37% of project abstracts addressing conflict/post conflict), 'human capacity' and 'social ecology' (37% of project abstracts addressing conflict/post conflict) and 'culture and values' and 'social ecology' (25% of project abstracts addressing conflict/post conflict). The non-significant relationships included the cross reference of the categories of 'social ecology', 'culture and values' and 'human capacity' (12% of project abstracts addressing conflict/post conflict situations).

A single cross reference that was barely significant in the conflict/post conflict subsection that was not significant in the post natural disasters subsection was the cross reference of the 'culture and values' and 'human capacity' categories. Overall, when analyzing these two subsections separately, the data indicates that CIDA is funding agencies that are addressing the same type of populations and using psychosocial interventions to address mental health issues whether it is in post natural disaster or conflict/post conflict situations. It is likely that the psychosocial interventions used in these situations will be accompanied by different complementary interventions depending on whether it is conflict/post conflict or post natural disaster. For example, in the case of

post natural disaster situations, there would be a need to address preventive measures to avert potential environmental deterioration (landslides, collapse of dams, outbreak of disease, etc.). In conflict/post conflict situations, the preventive measures may need to attempt to prevent the escalation of violence (distribution of resources, mediating increasing ethnic rivalry, border issues, etc).

Conclusion

After analyzing the data based on the regions, Asia represented a large majority of the projects that had taken place post natural disaster. Sub Saharan Africa, North Africa and the Middle East and Eastern Europe had a more even distribution among projects addressing conflict/post conflict situations. The South and South East Asian tsunami of 2004 not only had an effect on the number of projects taking place in the Asia region but the funding for projects that had a component of mental health increased two-fold in that year as a result.

Another highly relevant finding was that 'girls and women' were mentioned in forty one (41) of the forty seven (47) project abstracts. Additionally, the significant relationship between the 'human capacity', 'social ecology' and 'culture and values' categories indicated a strong attempt at using psychosocial interventions to address mental health issues. Furthermore, the significant relationship of the co-occurrence of 'human capacity' with either 'social ecology' or 'culture and values' represented a strong focus on interventions that combined the psycho (individual) and social (social connections). When 'human capacity' was cross referenced with 'girls and women', 'Asia' and 'multilateral' nodes, significant relationships were represented in each case. Another interesting finding

appeared in the analysis of co-occurrences when the 'multilateral' node was cross referenced with the 'human capacity', 'social ecology' and 'culture and values' categories. Only the cross reference with 'human capacity' represented a significant relationship. When the 'bilateral' and 'partnership' nodes were cross referenced with the 'human capacity', 'social ecology' and 'culture and values' categories, each relationship was significant. Lastly, the comparison between project abstracts addressing conflict/post conflict and post natural disasters demonstrated that CIDA addressed similar areas for each.

Overall, it is possible to conclude that the data indicated that psychosocial interventions are the preferred mental health intervention within CIDA. This supports my hypothesis that *"the international development policies and programming of CIDA will be informed by the current international policy framework that addresses mental health issues through a psychosocial theoretical perspective"*. Furthermore, as was outlined in Chapter II: Theoretical Framework, social workers are best suited to deliver psychosocial interventions. The finding that psychosocial interventions are the preferred mental health intervention in CIDA is therefore an important finding for the field of social work in international development. The next chapter, which will examine a Project Approval Document (PAD), will provide some clarity as to whether the project abstracts are an accurate representation of project activities.

Chapter VII: Palestine project comparison

Introduction

This chapter will first provide a summary of the document describing the Palestine Project DAP Project Approval Document (PAD). The results of the coding of the PAD and its corresponding project abstracts will then be presented.⁴³ Next, the results of the coding of the PAD will be compared to those obtained through the coding of the project abstracts. An analysis of the similarities and differences in coding between the two project abstracts and the PAD will then be presented. This will include outlining similarities and differences in the coding of the categories 'human capacity', 'social ecology' and 'culture and values'.

Whereas the two project abstracts provided a brief description of the projects, the PAD offered a more extensive description and explanation of the project. The PAD allowed for a more in depth analysis and its comparison with the project abstracts offered insight into whether the project abstracts supplied an accurate representation of the project details.

The project purpose and the project goals are addressed in both the project abstracts and the PAD. Sections included in the PAD which are excluded from the project abstracts are: expected results, expected outcome of project, outcome indicators, outputs of project, output indicators, beneficiaries, links to Canadian ODA (Overseas Development Assistance) and CIDA priorities, risk and mitigation strategies,

⁴³ The Palestine Project PAD contains two phases included in two different project abstracts; CIDA project abstract # A031045 (Well Being of Palestine Children), which represents the first phase of the project, and CIDA project abstract # A031452 (Child Well Being, Phase II) which represents the second phase of the project .

consultations (with the partners involved in the process), estimated cost and duration, and the management and contract plan.

Summary of PAD

The PAD begins by highlighting the high level of violence in the Palestinian territories and its effect on children. There are approximately 9000 children who have been wounded as a result of the ongoing conflict, many of whom will carry emotional and physical scars with them forever. The PAD summary indicates that children who grow up in violence are more likely to engage in violence as adults. According to the PAD, the different facets of conflict affecting children are: poverty, cramped living conditions, gender discrimination, domestic violence, poor education, lack of opportunities to express themselves, issues of identity and lack of hope. Since 55% of the Palestinian population is under 25 years of age (CIDA, n.p.), the ongoing conflict severely affects the ability of the society to heal and work towards peace. Furthermore, the PAD mentions that it is difficult for local organizations to offer services because of a lack of human resources and practical problems such as school and road closures as well as violence.

The failure of talks between Israeli and Palestinian elites to improve the situation is also outlined. Through the implementation of this project, CIDA is seeking to demonstrate solidarity between Canada and Palestine by supporting the Palestinian government in attempts to address the immediate mental health needs of the population and by making efforts to ensure sustainable, longer-term development. Specifically stated in the PAD, "CIDA has been asked to support efforts towards the psycho-social and physical well-being of children traumatized by violence" (CIDA, n.p.). CIDA's focus will

therefore be on the urgent psycho-social and physical needs of the population and the prevention of psychosocial distress in the longer term.

The section termed 'current situation' in the PAD outlines the role of the Palestinian Ministry of Planning and International Cooperation (MOPIC)'s Secretariat for the National Plan of Action for Palestinian Children. The role of this plan was to improve the quantity and quality of integrated and preventive community-based psycho-social and mental health services, particularly for children. CIDA was asked by the Palestinian government to help with the integration of this plan. It was determined that CIDA could contribute towards efforts to co-ordinate and integrate actions of the government and NGOs towards one coherent national strategy that "effectively empowers Palestinians with the skills and knowledge to increase childhood resiliency and proper childhood coping and development strategies" (CIDA, n.p.).

In the 'description' subtitle of the PAD, CIDA outlines its role to facilitate the co-ordination and co-operation across agencies and to improve their delivery of services in the area of psycho-social and physical support services to Palestinian children, their families and communities. The two phases of the project are also outlined in the description section. The first phase will involve support to four or five local Palestinian NGOs that will provide the Palestinian population with psycho-social counseling and physical rehabilitation. The second phase will focus on encouraging prevention of long term negative effects of trauma and the integration of services currently available. As indicated in the PAD, this will involve institutional strengthening within the government and training for methods of non-violent means to deal effectively with trauma.

The PAD then outlines the goal of the project which is to “provide Palestinians with the basic skills to deal with the effects of conflict and to decrease incidence of mental illness resulting from trauma associated with violence” (CIDA, n.p.) and the purpose of the project which is “to increase children’s resilience to trauma related to violence, by enabling NGOs and other agencies to provide more quality services to them, their families and communities” (CIDA, n.p.) of the project.

The ‘expected outcomes’ of the project outlined in the PAD are: 1) Palestinian children themselves are more able to cope with trauma, 2) families and communities are better equipped to deal with their traumatized children in constructive ways and 3) improved co-ordination and integration of service providers to treat traumatized children, their families and communities. Other important sections included in the PAD are: beneficiaries, links to Canadian ODA and CIDA priorities, risk and mitigation strategies, consultations conducted about proposed approach, estimated cost and duration, and the management and contract plan⁴⁴.

⁴⁴ Please see Appendix D: Palestine Project Approval Document to view the full project report.

Results: CIDA PAD Project (Palestine Project DAP) - Categories

This visual represents the PAD and all the categories that have been coded in it. The categories illustrated include: explicit psychosocial, culture and values, social ecology, service providers, population targeted, human capacity, and explicit mental health.

Results: CIDA PAD Project (Palestine Project DAP) - Categories and nodes

This visual represents the PAD and the categories that have been coded in it. It also illustrates all the nodes that contribute to the category of service providers. Each category has a different set of nodes that have contributed to them. Please see the next page for a representation of all categories and nodes contributing to them.

CODING: All categories and nodes of Palestine Project PAD

Summary of categories⁴⁵

Category	Sources	Ref ⁴⁶
Culture and values	1	15
Nodes	Sources	Ref
Better equipped	1	2
Integrate actions	1	1
Integration	1	4
Prevention	1	1
Strengthening	1	1
Support to NGO's	1	1
Tools to deal with conflict	1	2
Support to peace	1	1
Community based prevention	1	2
Category	Sources	Ref
Human capacity	1	30
Nodes	Sources	Ref
Capacity building	1	2
Coping Skills Training	1	5
Counselling	1	1
Empowers	1	1
Increase resiliency	1	4
Physical and social well being	1	1
Physical rehabilitation	1	3
Physical trauma	1	1
Skills and knowledge	1	1
Support human security	1	1
Trauma	1	8
Emotional maturity	1	1
Enabling	1	1

⁴⁵ The numbers **in bold** represent the nodes with the highest number of references.

⁴⁶ References

Category		Sources	Ref
Explicit mental health		1	3
	Name	Sources	Ref
	Improve mental health	1	1
	Mental health services	1	2
Category		Sources	Ref
Population targeted		1	36
	Name	Sources	Ref
	Children	1	16
	Children and families	1	8
	Communities	1	7
	Palestinians	1	2
	Teachers	1	1
	Young adults	1	1
	Youth	1	1
Category		Sources	Ref
Explicit psychosocial		1	3
	Name	Sources	Ref
	Psychosocial and physical trauma	1	1
	Psychosocial counselling	1	1
	Psychosocial evaluation	1	1
Category		Sources	Ref
Service providers		1	11
	Name	Sources	Ref
	Facilitate coordination and cooperation	1	3
	Help for organizations to provide services	1	1
	Improve delivery of services	1	1
	Measurements of improvement	1	2
	Needs assessment	1	2
	Partners	1	2
Category		Sources	Ref
Social ecology		1	6
	Name	Sources	Ref
	Deal effectively with trauma	1	1
	Increase access	1	1
	Outreach programs	1	2
	Participation	1	1
	Participatory development	1	1

Summary of the project abstracts

First component of project

The first project abstract (CIDA project # A031045)⁴⁷ provides a brief summary of what is included in the PAD. This summary includes the number of children affected, the hope that Canada can represent solidarity with Palestine, the goal to address the urgent needs of the population by supporting psychosocial and physical rehabilitation efforts as well as efforts to promote long term development. It also mentions that CIDA will be facilitating co-operation and co-ordination across agencies (local Palestinian NGOs and the Palestinian government) to improve the delivery of psycho-social and physical rehabilitation services.

The first project abstract describes the first phase represented in the PAD. As was also presented in the PAD, the description indicates that Phase I will support five local NGOs in their efforts to address the psychosocial and physical needs of children through psychosocial counseling and physical rehabilitation. This project abstract also outlines CIDA's wish to improve "vertical coordination among relevant agencies". Overall, it indicates that CIDA's contribution will strengthen the capacity of Palestinian agencies and NGOs to more "effectively co-ordinate and deliver psychosocial services, develop policies and implement best practices" (CIDA, n.p.).

Second component of project

The second project abstract (CIDA project # A031452)⁴⁸ addresses the second phase of this project. Phase II outlines the negative psychosocial effects of conflict on

⁴⁷ Please see Appendix C: Complete List of Project Abstracts, page 149 for the full project abstract.

⁴⁸ Please see Appendix C: Complete List of Project Abstracts, page 150 for the full project abstract.

Palestinians, especially Palestinian children, and the threat it presents to the educational system as a result of a lack of access to schooling for children. This second project abstract focuses on child protection, education and empowering the population to actively participate in determining and meeting their needs, although there are no details given about how CIDAs strategy plans to accomplish this.

Phase II, as represented by this project abstract, is meant to build on Phase I. The output of Phase II is the participatory development, between NGO's and the Palestinian government, of a program design that will help increase coping skills and give "children, their teachers, families and communities the tools to deal with conflict by non-violent means and to deal effectively with trauma" (CIDA, n.p.), therefore strengthening human security in the Middle East. The first component of the second phase involves the development of child friendly learning environments and psychosocial counseling and education by UNICEF. The focus of the second component of the second phase is to improve the ability of families, communities, and child focused agencies to initiate, manage and evaluate community based psycho-social programs for children who are affected by the ongoing violence in the West Bank and Gaza Strip.

The second project abstract presents the same project goal and purpose as presented in the PAD. The goal is to "provide Palestinians with the basic skills to deal with the effects of conflict and to decrease incidence of mental illness resulting from trauma associated with violence" and the purpose is to "increase children's resilience to trauma related to violence, by enabling NGOs and other agencies to provide more quality services to them, their families and communities" (CIDA, n.p.).

Results: CIDA Project Abstract # A031045 and # A031452 - Categories

This visual represents the two project abstracts and all the categories that have been coded in it. The categories illustrated include: human capacity, explicit psychosocial, explicit mental health, population targeted, type of organization and region. The culture and values category was coded only for second project abstract # A031452 - Child Well Being.

Comparison of PAD and project abstracts coding

There were some interesting findings when combining the coding of the two project abstracts and comparing this to the coding done on the PAD. One similarity between the coding of the project abstracts and the PAD is that they both had nodes coded under the category 'explicit mental health'. There were two (2) nodes coded under the 'explicit mental health' category in the project abstracts and three (3) nodes coded under the same category in the PAD. Both the project abstracts and the PAD also contained nodes that contributed to the 'explicit psychosocial' category. Nodes that contributed to the 'explicit psychosocial' category were referenced three (3) times in the project abstracts and three (3) times in the PAD. These findings demonstrate that these two categories are represented fairly equally in the project abstracts and in the PAD. Since the PAD provides a more in depth description when compared to the project abstracts, the equal representation of these categories despite the clear difference in the length and depth of the summaries could be an indication of what is deemed important by CIDA to include in the brief description of the project abstracts.

The second similarity in coding between the project abstracts and the PAD is that in the two project abstracts, 'peace building and conflict resolution' was coded as a node with one (1) reference while in the PAD, 'tools to deal with conflict and support peace' was coded as a node with three (3) references. Both of these nodes contributed to the 'culture and values' category in both the project abstracts and the PAD. As was discovered in the document search outlined in the Chapter IV: Methodology, it is much easier for researchers and the general public to obtain the project abstracts than PADs. The project abstracts therefore represent information that is more easily available and

could reflect the information that CIDA would like to highlight to the public. The emergence of these nodes in both the project abstracts and the PAD could demonstrate that issues of conflict resolution and efforts to promote peace were key elements that CIDA wished to highlight through their inclusion in the project abstracts.

One area that the PAD expands upon that represents a difference from the project abstracts is in the 'population targeted' category. In the project abstracts the nodes of 'communities', 'families', 'children and families' and 'children' contributed to the category of 'population targeted'. In the PAD, these same nodes contribute to the 'population targeted' category but in addition, the nodes of 'Palestinians', 'teachers', 'young adults' and 'youth' are also included. The additional nodes coded in the PAD provide a more complete view of the different populations being targeted by the project. Additionally, the nodes of 'communities', 'families', 'children and families' and 'children' could be seen as the most important populations targeted as these are the nodes included in both the project abstracts and the PAD.

Another difference that emerged in the coding of the project abstracts and the PAD is the category of 'service providers'. This category was included as a result of the open coding process done in the PAD but did not appear from the open coding of the two project abstracts. There were six (6) nodes that contributed to the 'service providers' category in the PAD. The nodes included in this category are meant to indicate the role of the service providers in implementing the project goals. The nodes contributing to the category include: facilitation and co-ordination, help for organizations to provide services, improve delivery of services, measurements of improvement, needs assessment, and partners. The PAD therefore provides important information on the type of interventions

given by the service providers involved in the implementation of this project. As this information is missing from the project abstracts, it could indicate that CIDA is placing more importance on representing other information from the PAD in the two project abstracts.

Human capacity, social ecology and culture and values nodes

There were some interesting findings in regards to the nodes contributing to the ‘human capacity’, ‘social ecology’ and ‘culture and values’ categories in the project abstracts and the PAD. As has been determined in the previous Chapter VI: Results, the majority of CIDA’s mental health interventions are psychosocial. As psychosocial is defined as the interaction of these three categories (PSWG, 2003b), it is important to examine their interaction in the project abstracts as compared to the PAD. This will provide insight into whether the project abstracts represent the mental health approach taken in the PAD.

The ‘human capacity’ category was represented in both the project abstracts and the PAD. There were seven (7) nodes that contributed to the ‘human capacity’ category coded in the project abstracts. Within these seven (7) nodes, there were fourteen references. In the PAD, there were thirteen (13) nodes that contributed to the category of ‘human capacity’ and within these nodes there were twenty nine (29) references. Both these numbers represent the high prevalence of nodes addressing ‘human capacity’. Despite a larger number in the PAD, this category was fairly well represented in the project abstracts as well. Thus, it may be assumed that CIDA places importance on the representation of the category of ‘human capacity’.

The 'culture and values' category was well represented in the PAD with thirteen (13) nodes contributing to the category while the project abstracts contained only one (1) node contributing to the category. While the category of 'social ecology' was not mentioned once in the project abstracts there were seven (7) nodes contributing to the 'social ecology' category in the PAD. Furthermore, there is one reference in the project abstracts to the 'culture and values' category, none to the 'social ecology' category, and seven to the 'human capacity' category. This demonstrates that CIDA has chosen to represent 'human capacity' as the primary means of intervention in the project abstracts but has chosen to expand upon the other two categories in the PAD. It is possible that both 'culture and values' and 'social ecology' are more difficult to explain than other categories such as 'explicit psychosocial' or 'explicit mental health', which consist of one or two words. The possible difficulties in describing the component of 'social ecology' and 'culture and values' could have resulted in limited referencing to these categories in the shorter description of the project abstracts. This could suggest that CIDA is attempting to simplify the description in the two project abstracts for the public.

As has been demonstrated, all three categories of 'human capacity', 'social ecology' and 'culture and values' are represented in the PAD, however, the category 'human capacity' was predominant. Since psychosocial can be defined as the interaction of the psycho (individual) and social (IFRC, 2003; PSWG, 2003b)⁴⁹, the presence of the three categories is a demonstration that this project is using psychosocial interventions to address the situation. The difference between the project abstracts and the PAD is that the

⁴⁹ The definitions of psychosocial are discussed in the Chapter II: Theoretical Framework, p.18

psychosocial approach that is taken in this project is stated more explicitly through the PAD.

Conclusion

This chapter provided a comparison of the key points found in the PAD as well as in the two project abstracts. It then presented the results of the coding done in NVivo for the PAD and the project abstracts; followed by a discussion of the results of the open coding. This comparative analysis concluded that although the PAD did provide more project details, the project abstracts captured the general idea of the type of mental health interventions taking place. This study focused on exploring the type of mental health interventions being used by CIDA, and found that the project abstracts provided the essential information needed to conduct the analysis.

It is made clear through the project abstracts that the Palestine project is addressing mental health needs by using psychosocial interventions. This is accomplished in the project abstracts through the use of phrases such as mental health and psychosocial which are coded under the 'explicit mental health' and 'explicit psychosocial' categories. There were also numerous references to the 'human capacity' category in the project abstracts, which is a clear component of psychosocial. The overall conclusion taken from the analysis of the project abstracts was that CIDA uses predominantly psychosocial interventions to address mental health issues. Since both the project abstracts and the PAD represented a psychosocial approach, the information included in the PAD, although useful, did not significantly alter the conclusions taken from project abstracts.

Chapter VIII: Conclusion

The purpose of this study was to examine mental health interventions supported by CIDA. The sample under analysis included forty seven project abstracts that contained a component of mental health and one project approval document (PAD) which focused on mental health. Grounded theory and content analysis were applied to these documents and formed the basis for the analysis.

Mental health has a high prevalence worldwide and the risks of developing mental health issues increase following traumatic events such as conflicts or natural disasters (Patel, 2007). Additionally, scholarly literature demonstrates that the lower the socioeconomic position, the worse the overall health of the population (Raphael, 2004). Much of the population in developing countries lives in poverty which leads to poor health. This is exacerbated by a lack of human resources to address these problems thus increasing poor health outcomes, including mental health outcomes, for people living in developing countries. The high occurrence of traumatic events such as conflicts and natural disasters combined with poverty and a lack of human resources leaves people in developing countries at high risk of developing mental health issues.

Numerous factors have contributed to the development of CIDA's health policy. Health became a priority in the early 1970s and since that time has grown in importance until the eventual inclusion of mental health into the Agency's overall health policy. Mental health was included in CIDA's health policy as a result of influences from the international community, most notably, the publication of the *World Health Report 2001* (WHO, 2001a) which focused on mental health. In CIDA, health projects including those

that contain mental health components are funded by the multilateral, bilateral and partnership branches.

With respect to treatment in the field of mental health, a combination of different treatments is preferred by a large proportion of mental health professionals (Beitman et al, 2003 & Valenstein, 1998). This change in focus occurred in the last few decades when the concept of mental illness shifted to one of mental health. The concept recognizes that mental health is not solely the absence of disease but also the subjective sense of well-being. Mental health incorporates the social environment, primarily understood as the influence of one's family and community, as a crucial factor in the overall goal of health. The concepts of psychosocial well-being and psychosocial interventions address this new conception of mental health. The psychosocial definitions presented in this study were taken from different models of psychosocial interventions. Despite this, they all considered the individual and the intersection with his or her social environment, which is the core concept of psychosocial well-being. Social workers are best suited to understand and deliver psychosocial interventions as they are trained to consider the interaction between the individual and his or her social environment.

Recently, international organizations and scholars have developed numerous models of psychosocial interventions. The organizations presented in this study include: the Interagency Standing Committee, the WHO, The International Federation of the Red Cross/Red Crescent Societies, the Psychosocial Working Group, HealthNet TPO (Transcultural Psychosocial Organization), and the International Organization for Migration. Agger (2001) and Lykes and Mersky (2006) who address conflict/post conflict psychosocial interventions and reparations work are also included in this study.

The high global burden of disease associated with mental health issues demonstrates that more attention should be paid to this area of health. Research indicates that the risk of developing mental health issues is especially acute during post conflict and natural disaster situations (van Ommeren, Saxen & Samceno, 2005). When discussing mental health in developing countries, Patel (2007) identifies three key social determinants of mental health: loss, trauma and displacement as a consequence of conflict and disasters, poverty and gender inequality. Poverty and gender inequality in developing countries are contributing factors to the difficulties people will experience in conflict and natural disaster situations.

Several themes emerged from the analysis of the project abstracts. Firstly, the data indicated that CIDA consistently supported projects that attempted to address the needs of girls and women. A high number of projects included girls and women while references to boys and men were very infrequent. Secondly, the category of 'human capacity' was mentioned more frequently than 'social ecology' and 'culture and values', which are the other two components of psychosocial interventions. Finally, as a result of the South Asian tsunami of 2004, a large proportion of the projects were devoted to the Asia region. Other regions such as Sub Saharan Africa, North Africa and the Middle East and Eastern Europe had an even distribution of projects.

There were some significant differences in the type of interventions supported by the multilateral, bilateral and partnership branches. The 'multilateral' branch focused on 'human capacity' whereas the 'bilateral' and 'partnership' branches addressed all three areas of psychosocial interventions more evenly. CIDA has a higher level of control over bilateral and partnership projects. The agency therefore demonstrated a clear preference

for funding projects that included the interaction of all three areas of psychosocial interventions.

The findings supported the hypothesis of the study which was that “*the international development policies and programming of CIDA will be informed by the current international policy framework that addresses mental health issues through a psychosocial theoretical perspective*”. The leading international theoretical perspectives applied in conflict/post conflict and post natural disaster situations are psychosocial in nature. Although circumstances surrounding conflict/post conflict (distribution of resources, mediating increasing ethnic rivalry, border issues, etc) and post natural disasters (landslides, collapse of dams, outbreak of disease, etc.) can differ significantly, CIDA supports similar types of psychosocial interventions in both situations. The more extensive project description contained in the PAD supported this hypothesis as well. The PAD also demonstrated that although the additional information was useful, it did not significantly alter the conclusions that were drawn from the project abstracts. As way of concluding it can therefore be said that in conflict/post conflict and post natural disaster situations, CIDA supports psychosocial interventions to address mental health issues in harmony with the prevailing international policy framework.

Notwithstanding this germane finding that CIDA chooses a psychosocial intervention compatible with the prevailing international policy framework, overall, the data indicated that CIDA’s budget for mental health is relatively low. This provided evidence that the value placed on mental health interventions within CIDA is not major. Furthermore, the high global burden of disease associated with mental health issues demonstrates the need to increase funding for mental health in international development.

Despite a demonstrated need, this study highlighted that mental health is unevenly funded throughout the years included in this study. Due to the lack of sustained funding provided to mental health in the agency, it is unlikely that CIDA is contributing to the best of its abilities to the “*highest attainable standards of mental health in developing countries through its policies and programming*” as was stated in the research question.

The international literature indicates that psychosocial approaches are the most operative in addressing mental health needs in conflict/post conflict and post natural disaster situations. In Canada, social workers have a long history of working in the field of mental health. In addition, social workers are trained to be responsive to both the individual and the social environment. This training would enable them to be very valuable in international development projects where families, communities, culture and politics are often important considerations. Therefore, social workers are well equipped to take a leading role in the field of psychosocial interventions in international development.

Recommendations for further research

Although CIDA is supporting interventions that follow international perspectives and best practices, efforts should be made to determine the impact of these interventions. This would require in depth field research to assess the actual impact of CIDA supported interventions in selected countries. In depth interviews with persons involved in the projects including aid workers, social welfare workers, and recipients could be used to assess impact. Once effectiveness of interventions is determined, this will guide CIDA's future programming priorities in the area of mental health.

As outlined in the methodology, there are numerous areas where CIDA is funding projects that contain a component of mental health. The number of people experiencing HIV/AIDS worldwide is epidemic. Considering the large numbers of people affected, this may be one particular area of interest for further research. Those experiencing HIV/AIDS along with their families, friends and communities are more likely to experience mental health issues than those unaffected by the disease. Further research into the manner by which CIDA is addressing their mental health needs and the effectiveness of their interventions would be useful. This would help to alleviate some of the suffering experienced by the large number of people in developing countries experiencing the effects of HIV/AIDS.

One last area for research is in the area of international standards of human rights. Consideration might be given to developing policies that address major violations of human rights against people suffering from mental health issues. In order to uphold human rights standards, it will be necessary to develop and implement mental health policies in those countries where they do not already exist. Included in these policies should be the commitment for the future human resource development of multidisciplinary teams, including social workers, who are able to address mental health issues. Further research in this area would serve to highlight mental health as a human right and could ensure that mental health is considered when developing human rights policy and programming.

Role of this study in the literature

This study contributes to an expanding body of literature on the topic of mental health in international development. This growing body of literature will serve to enhance awareness among academics and the international community of the theories and practices used to alleviate mental health issues in developing countries. The study also identifies the meaningful contribution that social workers can make to mental health interventions in developing countries.

Appendix A: IASC Matrix of Interventions

IASC

Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Minimum Responses in the Midst of Emergencies

Area	A. Common functions
Coordination	1.1 Establish coordination of intersectoral mental health and psychosocial support
Assessment, monitoring and evaluation	2.1 Conduct assessments of mental health and psychosocial issues 2.2 Initiate participatory systems for monitoring and evaluation
Protection and human rights standards	3.1 Apply a human rights framework through mental health and psychosocial support 3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection 3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection
Human resources	4.1 Identify and recruit staff and engage volunteers who understand local culture 4.2 Enforce staff codes of conduct and ethical guidelines 4.3 Organise orientation and training of aid workers in mental health and psychosocial support 4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers
B. Core mental health and psychosocial supports	
Community mobilisation and support	5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors 5.2 Facilitate community self-help and social support 5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices 5.4 Facilitate support for young children (0–8 years) and their care-givers
Health services	6.1 Include specific psychological and social considerations in provision of general health care 6.2 Provide access to care for people with severe mental disorders 6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions 6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems 6.5 Minimise harm related to alcohol and other substance use
Education	7.1 Strengthen access to safe and supportive education
Dissemination of information	8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights 8.2 Provide access to information about positive coping methods
C. Social considerations in sectors	
Food security and nutrition	9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support
Shelter and site planning	10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
Water and sanitation	11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

The guidelines include 25 Action Sheets that explain how to implement each of the above minimum responses.

For further information, see <http://www.humanitarianinfo.org/iasc/content/products/default.asp> or email IASCmbpsa@who.net or IASCmbpsa@interaction.org

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Appendix B: Initial Open Coding Process

1) Southern Cone Technology Transfer

Open coding: **Region:** Chile; **Mental health:** health services, health promotion; **capacity building:** support, strengthen, contribute to development of institutional expertise; **location:** schools, workplaces, communities

Axial coding: Phenomenon- To support and strengthen the Chilean Ministry of Health's National Health Promotion Plan.

Causal conditions- The promotion of the country's four health priorities which include cardiovascular disease, mental health, accidents, and cancer need to be strengthened, particularly in the areas of schools, workplaces, communities and health services.

Consequences- By the end of this project there should be the development and implementation of national and regional health promotion as well as the development of infrastructures that are necessary for health promotion. The promotion of institutional expertise needed to implement programs and actions in mental health will be established.

2) Palestinian Child Well Being, Phase 2

Open coding: **Region:** Palestine, West Bank, Gaza Strip; **Population targeted:** families, communities. Children; **Mental health:** psycho-social counseling, mental health services; **Psychosocial:** psychosocial programs; **Conflict:** war, children affected by violence; **Timing of intervention:** prevention; **Capacity building:** developing, implement action plan, assemble services, support, co-ordination, strengthen the capacity x 2, develop policies, implement best practices, establishment of child friendly learning, initiate, manage, evaluate; community based,

Axial coding: Phenomenon: To improve the quality and quantity of integrated, preventive, and community-based psychosocial counseling and mental health services for children.

Causal conditions: There were fragmented and inadequate efforts to provide support to conflict/violence affected children in the West Bank and Gaza strip.

Consequences: There will be an improved coordinated effort of those who are working towards the well-being of children. The first component will establish a safe child friendly learning and play environment through UNICEF and their emergency programming in psycho-social counseling and education. The second component will build the capacity of families, communities, and child focused agencies to manage and evaluate community based psychosocial programs for children affected by violence in the area.

3) Sri Lanka Responsive Facility

Open coding: **Region:** Sri Lanka; **Population targeted:** women, gender based violence, children; **Mental health:** mental health service providers; **Natural disaster:** tsunami; **Capacity building:** training, governance; **Health**

Axial coding: ***Phenomenon***-Capacity building of local service providers in the government, non-government and educators to address relevant mental health issues of survivors of the tsunami, particularly women and children. ***Causal conditions***- After the devastation of the tsunami there was a lack of capacity within the government, non-government and educators to respond to mental health needs and gender based violence. ***Consequences*** -After the completion of the project, five main components will have been addressed. Firstly, there will be an improvement in the ability of the Sri Lankan governance. Secondly, there will be an increase in the awareness of gender discrimination within the government, non-government and educators. Through the development and support of training programs, there will be better trained professional and para-professionals. Government, non-government and educators will have the capacity to address gender based violence and develop school based health promotion for tsunami-affected children.

4) Tsunami 2004/Galle SL Reconstruction

Open coding: **Region:** Sri Lanka – Bermuda – Galle - Kalutara; **Population targeted:** women, families, youth; **Mental health:** counseling services, drug and alcohol abuse, HIV/AIDS; **Psychosocial:** psychosocial trauma; **Natural disaster:** tsunami; **Timing of intervention:** re-establishment; **Capacity building:** skills training, income generating brainstorming; housing

Axial coding: ***Phenomenon*** – This project focused on housing reconstruction and rebuilding capacity of the community in skills training and income generating activities in territory affected communities in Sri Lanka. It also developed community awareness activities to reduce gender based violence and to promote a smooth reunification of families. ***Causal conditions*** – As a result of the tsunami there was a lack of appropriate water and sanitation facilities, lack of sufficient housing, lack of community centers with services for the community. There was also a decrease in income-generating business and an increase in gender-based violence. ***Consequences*** – There will be an increase in the capacity of service centers to address the needs of the population. The housing component of the project will build 400 new houses and 150 new homes in Galle and

Kalutara. There will be the provision of homes with access to basic water and sanitation facilities and tsunami warning systems, as well as access to some counseling services. The hope is that community capacity will improve the livelihood of the communities. There will be the creation of income generated business to support the livelihood of women, families and youth. This section of the project is meant to aid 1,200 people with 50% of them being women. Finally, the project hopes to promote well being by reducing psychosocial trauma caused by gender based violence, alcohol and drug abuse and HIV.

5) Psycho-social rehabilitation

Open coding: **Region:** Guatemala; **Population targeted:** child, adult; **Mental health:** promotion of mental health; **Psychosocial:** psychosocial rehabilitation; **Timing of intervention:** rehabilitation; **Capacity building:** training; **Health,** public awareness,

Axial coding: *Phenomenon* – This project is improving mental health services in the areas of children, public awareness, and training.

Causal conditions - The lack of services available within the health care system for mental health needs. There was also a lack of services available for psycho-social rehabilitation, lack of awareness of mental health issues, and a need for improved services for children within Guatemala.

Consequences - Upon completion of the project, it is expected that mental health services are made available in the public health system. There should also be the establishment of services available to improve the mental health of children, training provided on the techniques of psycho-social rehabilitation and an increase in public awareness and promotion of mental health.

6) PERU/PAHO/Earthquake response June 2001

Open coding: **Region:** Peru; **Population targeted:** affected population; **Mental health;** **Natural disaster:** earthquake; **Health:** basic medical, outbreaks of disease, safe water; Control measures implemented,

Axial coding: *Phenomenon* – This project addresses the health and mental health needs after the 2001 earthquake in Peru.

Causal conditions – After the earthquake there was an increase for mental health services within the population.

Consequences – Upon completion of this project, basic medical and mental health needs of population are hoped to be addressed, outbreaks of diseases will be detected and monitored and control measures implemented, and safe water will be supplied to the affected population.

7) XW- WHO Indian Ocean Tsunami Appeal

Open coding: **Region:** Indonesia - Indian Ocean; **Population targeted:** child, women, maternal health; **Mental health:** mental health services; **Natural disaster:** tsunami; **Timing of intervention:** emergency response; **Health:** health infrastructure damage, water, sanitation; **Location:** quality of services hospitals, health centers.

Axial coding: *Phenomenon* – This project provides emergency health and mental health, water and sanitation services to Indonesia after the Indian Ocean tsunami. It also assessed the nature of the health infrastructure damage after the tsunami.

Causal conditions – There was damage to the quality of services in hospitals and health centers, the provision of child and maternal health and water and sanitation services after the tsunami. There was also a need to establish emergency health operation units.

Consequences – Upon completion of the project, emergency health operations units should have been established. Furthermore, there will have been an assessment of health infrastructure damage and quality of services in hospitals and health centers. Child and maternal health and mental health services will have been provided and water and sanitation services restored.

8) Hurricane Stan – PAHO Appeal

Open coding: **Region:** El Salvador; **Population targeted:** regions affected; **Mental health;** **Natural disaster:** hurricane, floods, rains, landslides, Iamatepec; **Timing of intervention:** restore; **Capacity building:** education, developing a monitoring system to avoid increases in morbidity and mortality rates; **Health:** basic hygiene, sanitation, provision of safe water.

Axial coding: *Phenomenon:* This project delivers immediate and effective health assistance as well as developing a monitoring system to avoid increases in morbidity and mortality after the devastation of Hurricane Stan in El Salvador.

Causal conditions: Damage was caused by Hurricane Stan to regions affected by rains, flooding, and landslides.

Consequences: The effects of these interventions will be the restoration of effective health assistance, development of a monitoring system that avoids increases in morbidity and mortality by actions in education, vector and rodent control, basic hygiene and sanitation, safe water, and actions in mental health

9) CLWR 96-99 Development Program

Open coding: **Region:** Mozambique; **Population targeted:** communities and partner organizations; **Mental health:** self help; **Conflict:** response to war; **Timing of intervention:** re-establish adequate livelihoods; **Capacity building:** strengthen, organizational capacity, support peace and reconciliation, promote, enhance educational opportunities, partner organizations, promote physical and mental health.

Axial coding: *Phenomenon:* This project represents organizational capacity building within communities and partner organizations after an armed conflict in Mozambique that promotes peace, health and mental health.

Causal conditions: The assumption is that as a result of conflict, the organizational capacity, livelihoods, physical and mental health and educational opportunities of the affect population in Mozambique have been weakened.

Consequences: At the end of the project, there should be a strengthening of organizational capacity that can support peace and reconciliation, the re-establishment of livelihoods, improved promotion of physical and mental health, and enhanced educational opportunities.

10) CCI General Program

Open coding: **Region:** Suriname, Guyana, Ghana, Swaziland, St. Vincent and Grenadines; **Population targeted:** adult, families; **Mental health:** suicide, suicide crisis line, drug abuse, counseling, counseling drug abuse patients; **Timing of intervention:** continuing care, drug abuse prevention, setting up; **Capacity building:** training in suicide prevention, worked alongside health care professionals, teaching about drugs and HIV/AIDS, training in mental health care, training to staff; **Health:** dental and communicable disease control; **Type of organization:** Salvation Army.

Axial coding: *Phenomenon:* Training in basic health care, suicide prevention, drug abuse prevention, and mental health care.

Causal conditions: Presumed causes for these interventions in the different regions is a lack of appropriate services in basic health care, suicide prevention, drug abuse prevention, and mental health care services.

Consequences: At the end of the project there will be an increased capacity of countries to address basic health care concerns, increased capacity to address and identify when suicide intervention and drug abuse prevention is needed. There will also be an increased capacity to treat mental health needs of affected populations.

11) 99-2000/2001-2002 SCC Program

Open coding: **Region:** Peru; **Population targeted:** children, boys and girls, families, teachers, police, family judges, peace judges, mental health workers, municipal, health and education sectors; **Mental health:** child abuse, abuse, psychological treatment, sexual

harassment and abuse, physical and sexual abuse, treatment, psycho therapeutic treatment;
Timing of intervention: prevention of child abuse inter family communication, improve;
Capacity building: training, promote, support their families, develop adequate support mechanisms, train police, family judges, peace judges, mental health workers; **Health;**
Location: schools, municipal child defense offices.

Axial coding: Phenomenon: Provide a treatment methodology for the treatment and prevention of child abuse and psycho-therapeutic treatment to boys and girls who have suffered abuse. This should improve family communication and allow the children to developed adequate support systems within the family. It is capacity building for the prevention of child abuse in Peru

Causal conditions: child abuse a major problem but there is little psychological support for treatment for children and families who experience abuse, including sexual harassment. There is limited knowledge among government and professionals in the area of effects of abuse and the treatment and prevention of it.

Consequences: The ensure the treatment of prevention of child abuse, to provide psycho therapeutic treatment to boys and girls who have been abused so that they can recuperate and support their families which will improve inter-family communication and develop adequate support mechanisms.

12) Match Program 99-2000 to 2002-2003

Open coding: **Region:** Lima, the Ministry of the status of women; **Population targeted:** women; **Mental health:** domestic violence, counseling; **Capacity building:** training in gender issues, increase access to services, opening shelters, community resources; **Type of organization:** La Voz.

Axial coding: Phenomenon: This project supported the creation of a new shelter and provided training on gender issues. An increase in access to services for women in the area.

Causal conditions: La Voz womens' shelter has been lobbying the government on community development and human rights issues for women victims of domestic violence in a marginalized community on the outskirts of Lima. La Voz was asked by the Ministry of the Status of Women to address the issue of violence against women across the country.

Consequences: Upon completion of the project, there will be a number of new shelters open across the country. There will be an increased capacity of women to address gender issues. There will be an increase in the number of women across the country that have received training in

counseling, legal aid and mental health. Overall, there will be an increased capacity of the community to provide community resources.

13) Oxfam 3 year program, 99-2000 to 2001-2002

Open coding: **Region:** Zimbabwe; **Population targeted:** individuals, families, children, women, prisoners; **Mental health:** communal healing, violence and mental health, coping strategies, social support, counseled, psychological; **Conflict:** political and gender violence; **Capacity building:** strengthening, mental health care training, counseled, increased participation, facilitated.

Axial coding: *Phenomenon:* This project addresses the mental health needs of those affected by political and gender violence.

Causal conditions: In the past, there was political and gender violence in Zimbabwe that weakened the populations social support and coping strategies.

Consequences: This project hopes to increase participation in the development of the region and community, and facilitate community healing processes leading to reconciliation with the past. The project was successful in changing the government's attitude towards the victims as was demonstrated when President Mugabe made a public apology to the victims of the violence.

14) MCC Canada Program 1999-2002

Open coding: **Region:** Palestine; **Population targeted:** women, children, prisoners, refugees; **Mental health:** community mental health, trauma healing, conflict interventions; **Conflict: sub category** - response to war, peacebuilding, conflict resolution, rebuild a home; **Capacity building:** training advocated, implement peer mediators, Youth Advocates Training Program; **Type of organization:** Wi'am Conflict Resolution Centre, Gaza Community Health Program, Badil Refugee Resource Centre.

Axial coding: *Phenomenon:* This project is about the training of personnel in peace building and conflict resolution in Palestine.

Causal conditions: As a result of the war, there is a need to address the effects of violence on the population, specifically children, youth, women and prisoners.

Consequences: Volunteers on this project worked in research, advocacy, and mental health on issues that addressed the effects of violence on mental health especially of children, women, and prisoners. They also worked rebuilding homes, as peer mediators, youth advocates, running training at the summer peace building institute as well as information and awareness raising, training in peace building and workshops on trauma healing for children.

15) SIM Three year program 2000-2003

Open coding: **Region:** Mongolia; **Population targeted:** doctors, social workers; **Mental health:** alcohol abuse reduction, Alcoholics Anonymous; **Timing of intervention:** alcohol abuse reduction; **Capacity building:** train, teaches doctors and social workers, **Time frame:** 2000-2003

Axial coding: *Phenomenon:* Implementation of successful alcohol abuse reductions programs across the country.

Causal conditions: There is a high prevalence of alcohol abuse in Mongolia. Methods of treating it have not been successful.

Consequences: There has been success using the AA (Alcoholics Anonymous) methods of treating alcohol abuse. This project will train doctors and social workers to deal with the problem using this method. The goal is to train enough people about the program so that these treatment methods can be used around the country.

16) CTR Ressources non-violence/YA 2000-2001

Open coding: **Region:** Guatemala; **Population targeted:** rural communities; **Mental health:** community mental health in war affected regions; **Conflict:** mental health in war affected regions, response to war, peace accord; **Timing of intervention:** national reconstruction; **Capacity building:** support, collaboration, gradual transformation of social, cultural, and political structure, partner organizations, advise legal proceedings for crimes against humanity; **Time frame:** 2000-2001; **Type of organization:** Centre de Ressources Sur la Non-Violence, CRNV; **Type of community:** rural communities.

Axial coding: *Phenomenon:* Since the signing of the peace accords in 1996, there have been significant social, cultural and political challenges. The intervention in this project is to support rural communities and human rights organizations to thwart impunity measures in Guatemala.

Causal conditions: The need for this support has arisen from human rights violations as a result of violent conflict in Guatemala.

Consequences: The hoped outcome of this project is the gradual transformation of the country's overall social, cultural and political structure. This will be achieved through support and advice to local communities in the areas of exhumation of clandestine cemeteries, legal proceedings for crimes against humanity and community mental health in war affected regions.

17) CMHA Mental health action strategies

Open coding: **Region:** Zambia, Zimbabwe, South Africa, Algeria; **Population targeted:** person's with disability; **Mental health:** persons with disabilities; **Capacity building:** strengthening, sustainable and democratic development; **Time frame:** 2000-2003

Axial coding: *Phenomenon:* The intervention of this project is to contribute to sustainable and democratic development by strengthening counterparts which will therefore improve services for those with disabilities
Causal conditions: The government and organizations in Zambia, Zimbabwe, South Africa and Algeria are not meeting the needs of their communities and those experience disabilities within it in a sustainable and democratic manner.
Consequences: It is expected that this project will strengthen the ability of organizations in Zambia, Zimbabwe, and South Africa and the African Regional Council to better serve their communities in a manner which is sustainable and democratic thus improving services for those with disabilities in South Africa and Algeria.

18) PCC Three Year Development Program 00/01

Open Coding: **Region:** Rincon, San Antonio & Llano Grande & Ciudad Sandino; **Population targeted:** school children, community leaders, women, victims of Hurricane Mitch, families, educators, parents, young women; **Mental health:** mental health and psychological services, STD among women; **Natural disaster:** Hurricane Mitch; **Timing of intervention:** poverty reduction; **Capacity building:** facilitating training, vocational training, supporting micro-enterprises; **Health:** preventative health, nutritional improvements, nutritional habits; **Time frame:** 2001-2003; **Location:** home and schools; shelter, new housing, , basic education type of community (urban, rural),

Axial coding: *Phenomenon:* Housing provided and capacity building in the areas of schooling, community leaders, vocational training of women, micro-enterprises set up by women, and mental health and psychological services to recover from the effects of Hurricane Mitch
Causal conditions: These resources to address the needs of those affected are being provided after the devastation of Hurricane Mitch.
Consequences: a) better trained educators in their respective fields b) children will practice healthy hygiene and nutritional habits c) parents will be better able to support their children in home and school activities, d) poverty reduction for victims of hurricane, e) reduction of STD's in young women, f) development of women running micro enterprise, g) housing built for victims of the hurricane, h) improvement of nutrition in 120 families.

19) Inter Pares Program 2000-2005

Open coding: **Region:** State of Chiapas; **Population targeted:** displaced population of Las Abejas; **Mental health;** **Capacity building:** community-based training.

Axial coding: *Phenomenon:* One focus of the intervention of this project is on the analysis and diffusion on the political, social, economic and human rights situation. Another focus is the mental health needs of the displaced population of Las Abejas.

Causal conditions: The need for these interventions arose because there was a need to improve the political, social, economic, social and human rights situation in the State of Chiapas. Additionally, the mental health needs of the displaced population of Las Abejas were not being adequately addressed.

Consequences: At the end of this project it is hoped that there will be a diffusion of the tension within the political, social, economic, and human rights situation in the State of Chiapas. Furthermore, there will be mental health workers trained to address the needs of the displaced population of Las Abejas.

20) CIDEP – Adopt a School in El Salvador/Horizons of Friendship

Open coding: **Region:** El Salvador, La Paz, San Vicente, rural; **Population targeted:** 700 students, teachers, parents; **Mental health:** social psychology, post traumatic stress disorder, psychological, social development of child, improving the quality of life; **Natural disaster:** earthquake; **Timing of intervention:** reconstruction post earthquake, develops; **Capacity building:** support innovation, development of national and local national education, exchanging experiences, supporting organizations, broader reconstruction; **Location:** schools, education centers.

Axial coding: *Phenomenon:* This project is a response to the earthquake in El Salvador. It aims improve the psychological and social development of the child population, parents and teachers through the development of a social psychology program and treatment centers for PTSD in 5 schools.

Causal conditions: During the reconstruction phase, there was a lack of treatment within the schools of the trauma that arose due to the earthquake.

Consequences: The results of this project were an increase in psychological attention to students, parents and teachers. Specifically, five more school centers gave psychological care to students and staff. As a result, problems such as lack of confidence, sadness, depression, fatigue and passivity addressed and an improvement in attendance and participation was observed.

21) ASPS – Promoting Citizen Participation/ Horizons of Friendship (**not finished, unclear, need to email Stephane**)

Open coding: **Region:** El Salvador; **Population targeted:** women, families; **Mental health:** psychological, debilitating, despair, loss of control, stress; **Natural disaster:** earthquake, droughts; **Timing of intervention:** post, reconstruction; **Capacity building:** education, infrastructure; **Health;** **Location:** education centers; **Type of organization:** labour organizations, agricultural associations, and university women's association.

Axial coding: *Phenomenon:* improving health in rural communities with community participation as a result of natural disasters.

Causal conditions: droughts and floods, earthquakes and the resulting material destruction and social disorganization including psychological effects.

Consequences: 1, 820 people (52% women) and 2, 005 families will increase the level of local organization to respond to government and non-government organizations.

22) Horizons of Friendship/El Salvador post earthquake project

Open coding: **Region:** El Salvador; **Mental health:** counseling, post-trauma mental health needs; **Natural disaster:** earthquake; **Timing of intervention:** post-earthquake; **Health:** water and sanitation needs; **Type of organization:** PAHO.

Axial coding: *Phenomenon:* This project aims to address the immediate health and mental health needs of the population in El Salvador after the earthquake.

Causal conditions: There was limited capacity and resources because of earthquake in the areas of health and mental health.

Consequences: As a result of this project, there should be improved health, water and sanitation needs, education on health, sanitation and disaster mitigation. They should also have improved control of insect disease vectors. Lastly, there will have been the development of counseling to address the post-trauma mental health needs of the population.

23) The Canadian Association of Elizabeth Fry Societies, Women's Critical Resistance

Open coding: **Region:** Cameroon; conference, **Population targeted:** women's equality-seeking groups, legal practitioners, service providers, front-line anti-violence workers, academics, women and girls in and from shelters, prisons and child welfare, psychiatric and mental health and juvenile justice sectors, regional, provincial, local and internationally; **Location:** Ottawa; Time frame: 2001 – 2002.

Axial coding: Phenomenon: This conference brings together a variety of groups to discuss a variety of different issues.

Causal conditions: There was a need for different groups from across the country to connect in the 'critical resistance' movement to share ideas and brainstorm.

Consequences: The result should be a sharing of ideas and brainstorming. Connections with people interested in the same area of work should also be made.

24) Peru Mental Health and Human Development. Association of Universities and Colleges of Canada

Open coding: **Region**: Lima, Peru; **Population targeted**: undergraduate, graduate students, faculty, staff – subcategory: professionals targeted: mental health workers, health professionals, public health specialists, social scientists, primary health care workers; **Mental health**: in-service training, social and cultural psychiatry, social psychiatry, community based mental health services, community mental health, mental disorders, mental health policy innovations, mental health workers; **Psychosocial**: psychosocial health; **Capacity building**: strengthening, capacity to educate and train in field of mental health, courses, fellowships, scholarships, teaching modules, in-service training, improved, sustainable partnership, sustainability of linkages; **Health**: public health; **Location**: Universidad de Peruana Cayetano Heredia.

Axial coding: Phenomenon: This project developed skills and trained health graduate students and professionals. This capacity building was done in the areas of human resource development, continuing education, curriculum development with an emphasis on social and cultural psychiatry, and community based mental health services.

Causal conditions: There was a need for this capacity building because of a lack of development of people trained in the field of mental health and human development.

Consequences: Through these training courses, fellowships and scholarships it is expected that there will be better qualified university graduates that are able to address psycho-social health and community mental health. There will be an integration of teaching modules in social psychiatry, psychosocial health and community mental health, continuing education and in-service training program in community mental health. Furthermore, there will be an update of databases and algorithms. The development of mental health policy innovations and sustainable linkages after the project funded has ended is expected.

25) Child Law Kenya/ Save the Children Canada

Open coding: **Region:** Eastern Kenya; **Population targeted:** children, caregivers;

Mental health: protection of children with disabilities, mentally disabled children, children born out of wedlock, working children, child victims of drug abuse, victims of FGM and child trafficking; **Capacity building:** training workshops, training of children members of children rights clubs; **Knowledge transfer:** raising awareness, educating community leaders.

Axial coding: *Phenomenon:* Through training workshops, the intervention of this project is to raise awareness and educate community leaders, policy makers, children and caregivers in order to attempt to ensure a commitment to a newly enacted law protecting the human rights of children.

Causal conditions: There was a lack of knowledge and understanding of a new law that was enacted addressing the legislation gap that existed in the areas of protection for children with disabilities, mentally disabled children, children born out of wedlock, working children, child victims of drug abuse, and victims of FGM and child trafficking.

Consequences: The hoped outcome of the project is a new commitment from the 240 leaders and policy makers, children and caregivers to promote and protect the human rights of children within the confines of the newly enacted law.

26) 6ieme conference mondial pour la prevention et le control des (project description in French).

Open coding: **Region:** Montreal ; **Mental health :** prevention de traumatismes tant intentionnels que non intentionnels, traumatizes, suicide, violence ; **Capacity building:** transfert de connaissances.

Axial Coding: *Phenomenon:* This conference is about sharing knowledge about preventing violence/trauma, both intentional and not intentional violence.

Causal conditions: It was recognized that there was a need to organize different methods and strategies from different agencies.

Consequences: The hope of this project is an increased capacity and knowledge building between many different organizations.

27) CCI Program Support

Open coding: **Region:** St. Vincent and Grenadines; **Mental health:** mental health counselor, group counseling, mentally ill patients, international patients; **Time frame:** 2002-2004; **Type of organization:** Canadian Cross roads International.

Axial coding: *Phenomenon:* This project uses group counseling to treat the mentally ill.

Causal conditions: There was a need for an assistance mental health counselor.

Consequences: The outcome will be that the assistant will have a chance to observe some group counseling.

28) Maharashtra Seva: Schizophrenia Awareness

Open coding: **Region:** India; **Population targeted:** assist families, patients, caregivers; **Mental health:** schizophrenia, patient, self-confidence, self sufficiency, counseling family members, social skills for reintegration into society; **Timing of intervention:** reinstall, reintegration; **Capacity building:** training;

Axial coding: Phenomenon: raising awareness about schizophrenia and capacity building around the issues of reintegration into society
Causal conditions: limited knowledge of the effects of schizophrenia on patients and their families. A system to support reintegration into society is not well established.
Consequences: more open discussion about schizophrenia, better support for families and other caregivers who have a member who experiences schizophrenia, support for patients with schizophrenia to help with social skills in order to reintegrate into society.

29) Inter Pares Program./LA PE Institutional Strengthening

Open coding: **Region:** Peru; **Population targeted:** women, indigenous women, families; **Mental health:** post trauma assistance, mental health, sexual violence against women; **Capacity building:** strengthening citizen's voice, promote women's full citizenship, strengthening, information workshops, communications assistance, support campaigns against impunity, promote participation, influence peaceful debate of plans and strategies.

Axial coding: Phenomenon: The intended intervention of this project is capacity building in the area of strengthening citizens voices and influence over decisions that affect their lives with a focus on indigenous women. Particular focus will be given to strengthening indigenous women's organizing and participation.
Causal conditions: A presumed cause of this project is that the government is not sufficiently accountable or responsive to the needs of its citizens.
Consequences: It is expected that within the communities there will be enhanced capacity of people and particularly women, indigenous and poor, to participate and influence debates locally, nationally, and internationally in the areas of social, political or development plans and strategies.

30) 8th World Conference Injury Prevention and Safety

Open coding: **Region:** Argentina Durban, South Africa; **Population targeted:** injury and safety researchers, practitioners and decision makers; **Mental health:** violence, suicide, unintentional injury, safety promotion; **Capacity building:** formulate and share, information translate into policies, injury prevention and safety promotion; **Time frame:** date (March 31 – April 5, 2006).

Axial coding: *Phenomenon:* For this project CIDA supported the participation of qualified representatives by providing funding to attend the conference. *Causal conditions:* This project is responding to the perceived need to bring together practitioners and decision makers to discuss injury prevention policies. *Consequences:* The outcome of the project will be to provide a forum where professionals and organizations can share information on the areas of prevention, control and research related to violence, suicide, unintentional injury and safety promotion.

31) Training for Mental Health

Open coding: **Region:** Estonia; **Mental health:** mental health, mental health centre; **Capacity building:** training; **Health:** health care, health care workers.

Axial coding: *Phenomenon:* The focus of this project is the training of mental health care workers. *Causal conditions:* The need for this project has arisen because of a lack of adequate training for mental health care workers and mental health centers. *Consequences:* The anticipated outcome of this project is an increase in capacity of mental health care workers.

32) Community Mental Health Services Development/Centre for Addictions and Mental Health

Open coding: **Region:** Estonia, Latvia, Lithuania; **Population targeted:** people with mental illness and disabilities; **Mental health:** community focused care, mental illness, community based treatment team; **Timing of intervention:** develop, special needs housing development; **Capacity building:** training and technical assistance, strengthen government and non-government initiatives, input from local government, sharing of resources at all levels; **Health:** disabilities; **Time frame:** 2000-2003; **Type of organization:** Centre for Mental Health Care, Soros Foundation - Toronto, Ministry of Health – Latvia, Ministry of Health –Lithuania, Ministry of Social Affairs – Estonia.

Axial coding: Phenomenon: This project intervened with the development of national level policies for improved community care as well as the demonstration of new approaches to special needs housing and community focused care for people with mental illness and disability.

Causal conditions: There was inadequate support provided for housing and community needs of those who are mentally ill or experience disability in Estonia.

Consequences: The outcome in Estonia was that there was support given for special needs housing development. In Latvia, there was the implementation of a community based treatment team and in Lithuania there was training and technical assistance provided to strengthen government and non-government initiatives.

33) Russian Federation Russia Disability Program/ Canadian Centre on Disability Studies

Open coding: **Region:** Russia; **Population targeted:** faculty, professionals, community leaders, people with disabilities, social work students, mental health, CBR, community living students, academia, government officials, businesses; **Mental health:** people with disabilities, social integration of people with disabilities; **Timing of intervention:** develop models for education, development and implementation; **Capacity building:** strengthening, support, promoting democratic values.

Axial coding: Phenomenon: The intervention is stabilizing civil society, governance and promoting democratic values, human rights, and inclusion of all citizens, specifically people with disabilities in Russia. To create models for education and preparation of faculty, professionals, community leaders and people with disabilities in Disability Studies, Social Work, Mental Health, CBR, and community living. To promote the inclusion of people with disabilities in public policy and support other organizations (NGO's) that will support this.

Causal conditions: There has been a lack of social stability in Russia and therefore those with disabilities have been neglected their human rights standards and excluded from social policy.

Consequences: The hoped outcome is a strengthening of civil society in Russia through the promotion of social change and contributing towards social and educational reform and social integration of people with disabilities.

34) BHP Youth and Health

Open coding: **Region:** Bosnia, Herzegovina, Republic of Serbia; **Population targeted:** youth; **Mental health:** health counseling, substance abuse, mental illness;

Timing of intervention: assist in preparation, support design and implementation; **Capacity building:** advise in the reform, strengthening; **Health:** healthy lifestyle choices, sexually transmitted infections, primary health care, "Strengthening the Health System in Bosnia"; **Time frame:** 2004-2009;

Axial coding: Phenomenon: To assist in the implementation of a substance abuse program

Causal conditions: a lack of available resources for those with mental illness and substance abuse issues.

Consequences: It is hoped that the health system in Bosnia will be strengthened.

Appendix C: Complete List of Project Abstracts

Conflict/Post Conflict Project Abstracts

A031045 Well-Being of Palestinian

Children

2001-01-02 2002-03-28 \$799,073.55 \$795,781.87 A031045001 Well-Being of Palestinian

Children OXFAM
QUÉBEC/GROUPE
CONSEIL CAC
INTERNATIONAL
INC.

Rationale:

Over the past month, violence has broken out in the Palestinian Territories. Media coverage has been extensive, and much of it has focussed on children as victims falling under Israeli Defence Force fire, and also, as victims being exploited by Palestinian militia groups. So far, an estimated 300 people have lost their lives, among them, at least 50 children (up to 18 years of age). Of the estimated 9000 wounded, many are children, some of whom will carry forever with them the emotional and physical scars. Children have regularly been exposed to various facets of this deep-rooted conflict, not the least are poverty, cramped living conditions, gender discrimination, domestic violence, poor education, lack of opportunities to express themselves, issues of identity and lack of hope for a brighter future, to name a few. The international community has been flooded with urgent appeals to support the Palestinians through this difficult crisis. Calls for international protection, medical aid, food, shelter and water continue to pour in. CIDA continues to seek ways in which Canada can demonstrate solidarity with the Palestinians by supporting their urgent needs, all the while ensuring that our investments are strategic and contribute to longer-term development. CIDA has been asked to support efforts towards psycho-social and physical well-being of children traumatized by violence. Contributing to this area could not only allow CIDA to respond to urgent needs, but also allows us to invest in the long term well-being of the future generation of Palestinians. CIDA's contribution to this project will be to facilitate co-ordination and co-operation across agencies and to improve their delivery of services in the area of psycho-social and physical support services to Palestinian children, their families and their communities.

Description:

PalestinianTOcp The first component of Phase I addresses the immediate urgent needs of Palestinian children by supporting four or five local NGOs that provide them with psycho-social counselling and physical rehabilitation. Financial assistance totalling \$800,000 for outreach programs, such as those being implemented by the Gaza Community Mental Health Centre and other Palestinian NGOs, is provided in order to help these organizations supply the increased need for services.

The second component of Phase I involves the drawing up of terms of reference and contracting of a project facilitator whose role it is to do an in-depth needs assessment to support the implementation of the national plan of action for Palestinian Children, identifying if there is a need for Canadian value-added. The

facilitator's main output is the participatory development of a programme design that constitutes Phase II. These coping and life skills will give children, their teachers, families and communities the tools to deal with conflict by non-violent means and to deal effectively with trauma.

A031452 CHILD WELL BEING, PHASE 2

2002-04-02 2007-07-31 \$5,000,000.00 \$2,650,000.00 A031452001 CHILD WELL BEING, PHASE 2 NPA SECRETARIAT OF THE NATIONAL PLAN OF ACTION FOR PALESTINIAN CHILDREN
PalestinianTOcp CHILD WELL BEING, PHASE 2

Rationale:

Hope for a peaceful resolution of the Palestinian-Israeli conflict suffered a serious setback when violence began to spiral out of control in late September 2000. That hope was completely shattered over the Israeli military incursions into the West Bank following a wave of deadly suicide bombings by Palestinian militants. Since March 29, 2002, there has been serious damage to Palestinian Authority institutions, local authorities, NGOs, academic institutions and the private sector. Some analysts believe that institutional development achieved since 1993, under the aegis of the Middle East Peace Process, has been lost. The Israeli policy of closure and unfettered settlement expansion have led to a de facto cantonization of the Palestinian territories and has restricted the free movement of people and goods. The Palestinian economy has unravelled and poverty has struck the majority of Palestinians, especially refugees living in overcrowded camps. Children, quite literally, have been caught in the crossfire Up to 500,000 children (1/4 of the population in the West Bank) no longer have access to schooling which will seriously threaten their long term educational and psycho-social development. Fifty schools have been destroyed, 11,000 classes have been missed, 55,000 teaching sessions have been lost. Recent military operations in the West Bank have stopped regular vaccination programs and destroyed water and sewage systems, leaving children vulnerable to infection and disease. Civilian deaths and sweeping arrests have led to a sharp rise poverty, leaving well over 30% of families with less than \$2/day on which to survive. In terms of purchasing power parity with Israel, this represents the overwhelming gap between the relatively wealthy Israeli society and poverty in the Palestinian territories. This gap, in turn, fuels tensions in an already complex and deep-rooted conflict. Economic and social stress within Palestinian society have led to increased family violence. This initiative is in line with CIDA's Social Development Agenda. It focuses on child protection and education. It supports democratic practices by empowering children, communities, and civil society to actively participate in determining their needs and in meeting them. It also strengthens human security in the Middle East by addressing a critical factor: i.e. childhood trauma and conflict, as contributors

Description:

CHILD WELL BEING, PHASE 2 As broached in the concept paper for Child Well Being II, the Palestinian Authority's Secretariat for the National Plan of Action for Children requested Canadian assistance to improve the quantity and quality of integrated, preventive and community-based psycho-social counselling and mental health services. The National Plan of Action was a first step on the way to developing, with partners, a national policy and co-ordinated actions to address the needs of conflict affected children throughout West Bank and Gaza Strip. There was a clear need to support the efforts of this Secretariat in its co-ordination capacity, especially in the ongoing context of violence and its effects on children. Resources were needed to implement the action plan and to assemble fragmented and inadequate services for community-based prevention and psycho-social programs as a positive contribution to peace and security in the West Bank and

Gaza. Indeed, CIDA saw a clear need and opportunity to support a Palestinian-led culture of peace by improving horizontal and vertical co-ordination among relevant agencies for the long-term benefit of Palestinian children. CIDA's contribution will improve the overall impact of combined and co-ordinated efforts by agencies and NGOs that are also working for the well-being of children. At a first stage, and in order to respond to the crisis, a contribution will be made to UNICEF to implement emergency programming in safe learning and play environments, psycho-social counselling and rights-based advocacy to promote knowledge and respect of children's rights as established in the Convention on the Rights of the Child. As part of an iterative approach, CIDA's contribution will also strengthen the capacity of Palestinian agencies and NGOs to more effectively co-ordinate and deliver psycho-social services, develop policies and implement best practices.

Phase II consists of the following:

Component I : The establishment of safe child friendly learning and play environments. This was delivered as a \$2,000,000 grant to UNICEF to implement its emergency program in psycho-social counselling and education. (2002-2004)

Component II: A contribution of \$3,000,000 to be managed by the National Plan of Action (NPA) with the stated purpose to "improve the ability of families, communities, and child focussed agencies to initiate, manage and evaluate community based, integrative psycho-social programs and services for children affected by the ongoing violence in the West Bank and Gaza Strip" (2004-2007)

Project role

(A031045001) Canada, through CIDA, provides financial contributions to Palestinian Organisations delivering services to traumatized children and youth, their families and communities.

Project Goal / Program Objective

(A031045001) This and future generations of Palestinians have the basic skills to deal with the effects of conflict. Decreased incidence of mental illness resulting from trauma associated to violence. (A031045PRE) Goal : To improve the psycho-social and physical well-being of Palestinians, thereby positively contributing to their ability to resolve conflict by non-violent means.

Proj.Purpose(Bil)/Proj.Objectives (CEE)

(A031045001) To increase children's resilience to trauma related to violence, by enabling NGOs and other agencies to provide more quality services to them, their families and communities.

(A031045PRE) Purpose : To increase children's resilience to trauma related to violence, by enabling NGOs and other agencies to provide more quality services to them, their families and communities.

Conflict/Post Conflict Project Abstracts Titles (project titles appear as received from CIDA)

S054871 99-2000/2001-2002 SCC

PROGRAM

1998-11-24 1900-01-01 \$7,011,000.00 \$7,011,000.00 S054871025

Psychosocial Practice Prev. Child Abuse

SAVE THE CHILDREN CANADA/ AIDE À

L'ENFANCE CANADA

Peru Psychosocial Practice Prev. Child Abuse

Location: Cuzco Inca Region (Cuzco, Madre de Dios,

Apurimac)

Project Project Name Start Date End Date Budget Disbursement WBS Number WBS Name
Executing Agency Country Description

S055068 FCM PROGRAM 99-02

**MUNICIPAL
DEVELOPMENT**

1998-11-20 2003-02-05 \$8,605,846.56 \$8,605,846.56 S055068069 Bangkok / Vancouver
FEDERATION OF CDN
MUNICIPALITIES

S055619 MCC CANADA

PROGRAM 1999-2002

1999-02-17 2002-12-31 \$9,705,000.00 \$9,705,000.00 S055619030 Peacebuilding & Conflict
Resolution
MENNONITE CENTRAL COMMITTEE OF CDA

A032199 War-Affected Youth 2003-08-28 2007-03-31 \$6,000,000.00 \$5,884,431.54

**A032199002 War-Affected Youth - Phase II DEFENCE FOR
CHILDREN**

Angola Project Description: War-Affected Youth - Phase II (please see attached for
complete text):

M004498 Albania/CECI/Support to Host Families

1999-04-16 1999-09-01 \$114,105.00 \$100,073.00 M004498001 Albania/CECI/Support to Host

**M004503 BALKANS/UNICEF/CHILD &
WOMEN**

1999-04-01 1999-12-31 \$1,000,000.00 \$953,076.39 M004503001 BALKANS/UNICEF/CHILD
& WOMEN UNICEF - New
York

**M010044 YUGOS/CECI/PROGRAMME
SOUTIEN FAM ACCEUIL**

1999-07-01 1999-12-31 \$200,000.00 \$164,396.00 M010044001 YUGOS/CECI/PROGRAMME
SOUTIEN FAM ACCEUIL

**M010046 ALBANIA/ICI/PSYCHO-SOCIAL
ASSISTANCE**

1999-06-11 2000-05-31 \$586,700.00 \$586,700.00 M010046001 ALBANIA/ICI/PSYCHO-
SOCIAL ASSISTANCE
INTERNATIONAL CHILDREN'S INSTITUTE

**M010454 MEDIA AND PEACE
EDUCATION IN AFGHANISTAN**

2000-07-25 2001-12-31 \$117,000.00 \$117,000.00 M010454001 MEDIA AND PEACE
EDUCATION IN
AFGHANISTAN
CENTRE FOR

PEACE STUDIES
MCMASTER
UNIVERSITY

M010543 S.LEONE/UNICEF/Child

Protection Prog.

2000-09-07 2001-06-30 \$700,000.00 \$700,000.00 M010543001 S.LEONE/UNICEF/Child
Protection Prog. UNICEF - New
York

M011268 Post-Conflict Stabilization &

Rehabilita

2003-03-03 2006-04-30 \$350,000.00 \$350,000.00 M011268001 Post-Conflict Stabilization &
Rehabilita McGill University
Office of
International
Research

M011454 R&R Former Child Soldiers -

Somalia

2003-02-03 2004-07-30 \$553,750.00 \$553,750.00 M011454001 R&R Former Child Soldiers -

M011604 Child Protection in eighteen provinces

2003-09-01 2005-08-31 \$1,000,000.00 \$1,000,000.00 M011604001 Child Protection in eighteen
provinces UNICEF Canada Angola

M011914 SD/World-Vision/Darfur child

friendly sp

2004-10-22 2005-04-15 \$298,754.63 \$298,754.63 M011914001 SD/World-Vision/Darfur-child
friendly sp World Vision
Canada

M012366 IFRC Lebanon 2006 2006-08-30 2006-12-31 \$1,000,000.00 \$1,000,000.00

M012366001 IFRC Lebanon 2006 RED CROSS INT'L

**AID TRUST OF
CANADA (FRCS)**

C/O INTER FEDE RED CROSS

S061279 MAP: Soutien Parascolaire 2001-04-03 2003-05-30 \$132,206.00 \$132,206.00

S061279001 MAP: Soutien Parascolaire MEDICAL AID FOR
PALESTINE

S061826 Plan International Canada Inc.

2002-2005

2002-07-02 2005-06-30 \$7,068,001.44 \$7,068,001.44 S061826001 Education Renewal, Sierra
Leone Plan International
Canada Inc. (Plan
Canada)

S062274 War Child Canada: Afghan

Women Community

2003-04-01 2004-08-30 \$88,200.00 \$88,200.00 S062274001 War Child Canada: Afghan Women

Community

S062692 CASS: Education & Community**Dev in S.**

2004-09-09 2007-12-31 \$151,720.00 \$40,000.00 S062692001 CASS: Education & Community
Dev in S. CANADIAN AID
FOR SOUTHERN
SUDAN

S062946 Inter Pares Program -

2005-2010

2005-04-01 2010-03-31 \$7,410,000.00 \$3,912,813.00 S062946026 LA-XA-CAMEX-Regional
INTER PARES El Salvador LA-XA-CAMEX-Regional

S063398 Prise en charge et réinsertion**des jeune**

2005-12-22 2007-01-31 \$117,276.00 \$99,329.00 S063398001 Prise en charge et réinsertion des
jeune AIDE MÉDICALE
INTERNATIONALE
À L'ENFANCE
Canada Prise en charge et réinsertion des jeunes de la rue dans la région de Butare
(Rwanda)

Z010951 BUILDING BRIDGES PROJECT 1997-11-15 2000-08-31 \$630,180.00 \$630,180.00

**Z010951001 BUILDING BRIDGES PROJECT INTERNATIONAL
CHILDREN'S
INSTITUTE**

Bosnia & Herz. BUILDING BRIDGES PROJECT T

A032037 Sri Lanka Peace Process --**UNICEF Grant**

2003-03-03 2004-03-31 \$2,200,000.00 \$2,200,000.00 A032037001 Sri Lanka Peace Process-
UNICEF Grant I UNICEF - New
York

Post Natural Disaster Project Abstract Titles(project titles appear as received from CIDA)**A032760007 Post Tsunami Mental Health Capacity**

CENTRE FOR ADDICTION & MENTAL HEALTH

2005-2008

\$16,504,150.00

M010888 PERU/PAHO/Earthquake

response June 2001

2001-07-01 2002-03-01 \$150,000.00 \$150,000.00 M010888001 PERU/PAHO/Earthquake
response June 2001

PAN-AMERICAN HEALTH ORGANIZATION

M012142 Hurricane Stan - PAHO

Appeal

2005-10-11 2006-01-31 \$175,000.00 \$175,000.00 M012142001 Hurricane Stan - PAHO

Appeal

PAN-AMERICAN HEALTH ORGANIZATION

S061205 Horiz/El Salvador pst earthquake project

2001-03-01 2002-06-28 \$100,000.00 \$100,000.00 S061205001 Horiz/El Salvador pst earthquake project

HORIZONS OF FRIENDSHIP

M011996 XW-WHO Indian Ocean**Tsunami Appeal**

2005-01-06 2005-06-06 \$1,500,000.00 \$1,500,000.00 M011996001 XW-WHO Indian Ocean

Tsunami Appeal

WORLD HEALTH

ORGANIZATION

Z020675 2005 UN CAP for North Caucasus (Russia)

2005-02-25 2005-12-30 \$3,500,000.00 \$3,500,000.00 Z020675001 2005 UN CAP OCHA United Nations Office for the Coordination of Humanitarian

Russian Fed. 2005 UN CAP OCHA

A032942 **Tsunami Sri Lanka Rehabilitation** 2006-03-21 2009-03-31 \$98,464.00 \$73,368.00

A032942001 Tsunami Sri Lanka Rehabilitation War Child Canada

A032999 TSUNAMI 2005-09-12 2006-12-01 \$517,214.06 \$517,213.54 A032999004 0205-209

CHILDREN OF THE TSUNAMI MYSTIQUE FILMS

LTD.

A033120 **UNICEF - Earthquake Recovery** 2005-12-22 2010-03-31 \$10,500,000.00

\$10,500,000.00 A033120001 UNICEF - Grant / Earthquake Recovery UNICEF - New York

A033365 **Facilitating Sust. Community**

Development

2007-01-10 2008-08-29 \$1,500,000.00 \$550,000.00 A033365001 Facilitating Sust. Community

Development Plan International

Canada Inc. (Plan

Canada)

A033370 **Rehabilitation Education Sector** 2006-09-01 2008-03-31 \$1,585,046.00 \$500,000.00

M012001 TSUNAMI 2004**MATCH/XW/UNICEF APPEAL**

2005-01-06 2005-06-06 \$15,213,758.00 \$15,213,758.00 M012001001 TSUNAMI 2004

MATCH/XW/UNICEF

APPEAL

M012069 TSUNAMI 2004

MATCHING/TH/CFHI

2004-12-27 2005-03-15 \$186,179.00 \$186,179.00 M012069001 TSUNAMI 2004
 MATCHING/TH/CFHI CANADIAN FOOD
 FOR THE
 HUNGRY
 INTERNATIONAL
 Indonesia TSUNAMI 2004 MATCHING/TH/CFHI

**M012080 Tsunami 2004 - IN - Save the
 Children**

2005-06-01 2006-08-31 \$1,108,667.00 \$1,108,667.00 M012080001 Tsunami 2004 - IN - Save the
 Children Save the Children
 Canada/ Aide à
 l'enfance Canada
 India

**M012116 Tsunami 2004 matching fund -
 IN - D&P**

2005-04-01 2006-03-31 \$734,225.00 \$734,225.00 M012116001 Tsunami 2004 matching fund -
 IN - D&P Développement et
 Paix/ Development
 and Peace
 India Tsunami 2004 matching fund - IN - D&P

**M012143001 Hurricane Stan- UNICEF Appeal UNICEF - New
 York**

\$375,000.00
 El Salvador Hurricane Stan/UNICEF/UN Flash Appeal

**M012159 Hurricane Stan -IFRC
 Emergency Appeal**

2005-10-21 2006-04-21 \$550,000.00 \$550,000.00 M012159001 Hurricane Stan -IFRC
 Emergency Appeal International
 Federation Red
 Cross
 Costa Rica Hurricane Stan/IFRC/Emergency Appeal

**M012178 S. Asia Earthquake - Foster
 Parents Plan**

2005-11-07 2006-05-06 \$400,000.00 \$400,000.00 M012178001 S. Asia Earthquake - Foster
 Parents Plan Plan International
 Canada Inc. (Plan
 Canada)
 Pakistan S. Asia Earthquake - Foster Parents Plan

**M012307 IFRC 2006 Indonesia
 Earthquake response**

2006-05-29 2007-01-28 \$1,650,000.00 \$1,650,000.00 M012307001 IFRC 2006 Indonesia
 Earthquake response RED CROSS INTL
 AID TRUST OF
 CANADA (FRCS)

C/O INTER FEDE
 RED CROSS
 Indonesia IFRC 2006 Indonesia Earthquake response

M012402 Typhoon Xangsane - IFRC

Appeal 2006

2006-11-07 2007-06-29 \$400,000.00 \$400,000.00 M012402001 Typhoon Xangsane - IFRC

Appeal 2006 RED CROSS INT'L

AID TRUST OF

CANADA (FRCS)

C/O INTER FEDE

RED CROSS

A032948 Tsunami 2004/Galle SL 2005-07-30 2009-03-31 \$3,251,742.00 \$500,000.00

A032948001 **Tsunami 2004/Galle SL THE SALVATION ARMY CANADA & BERMUDA** Sri Lanka Reconstruction Reconstruction

M012145 Pakistan Earthquake - CARE

Canada

2005-10-13 2006-04-13 \$500,000.00 \$479,056.00 M012145001 Pakistan Earthquake - CARE

Canada CARE Canada Pakistan Pakistan Earthquake/CARE Canada

M012191 Pakistan Child Protection and Education

2005-11-29 2007-04-30

Funding Budgeted : \$645,772.00

Funding distributed: \$645,772.00

Appendix D: Palestine Project Approval Document

Name: PALESTINE Project DAP - Protection des enfants3[1]

Description: Full project for analysis

¶1: Project Approval Document

¶2:

¶3: Background - Over the past month, violence has broken out in the Palestinian Territories. Media coverage has been extensive, and much of it has focussed on children as victims falling under Israeli Defence Force fire, and also, as victims being exploited by Palestinian militia groups. So far, an estimated 300 people have lost their lives, among them, at least 50 children (up to 18 years of age). Of the estimated 9000 wounded, many are children, some of whom will carry forever with them the emotional and physical scars.

¶4:

¶5: The causes of the current violence are complex. Indeed, this most recent outburst of violence, branded as the "Al Aksa Intifada" (or uprising) can be attributed to triggering factors, such as the visit by a notorious Israeli personality to a contested site in a land holy to both Muslims and Jews, but the real issues run deep in the minds and hearts of Palestinians and Israelis.

¶6:

¶7: Children have regularly been exposed to various facets of this deep-rooted conflict, not the least are poverty, cramped living conditions, gender discrimination, domestic violence, poor education, lack of opportunities to express themselves, issues of identity and lack of hope for a brighter future, to name a few.

¶8:

¶9: As the majority (55%) of the Palestinian population is under 25 years of age, the experience of violence and trauma affects this society's ability to heal and to progress towards a peaceful future. Although many local organizations are actively providing psycho-social counselling to children and their parents, their effectiveness is impaired by the lack of financial and human resources, the continuing violence, school closures and road closures that limit the mobility of persons to earn a living and acquire goods, including food.

¶10:

¶11: History has provided ample evidence demonstrating that children who grow up in violence, and who do not receive support that they need to overcome their psychological, spiritual or physical injuries, have a high propensity to engage in violence as adults. In the Middle East, and in particular, the Palestinian Territories, this rings true.

¶12:

¶13: One could argue that the current Al Aksa Intifada is the angry younger brother of the 1987-1993 Intifada. It is worrisome to note that the death toll of the Al Aksa Intifada is rising more quickly than that of the previous Intifada which lasted seven years. The more violent and armed Palestinian factions, most notably the Fatah Tanzim, are themselves graduates of the earlier Intifada. Their violent behaviour is an expression of the traumas they experienced during that time. It has also been observed that the prevalence of domestic or family violence, highly prevalent in West Bank and Gaza, can be associated with the scars of the Intifada and of life under Occupation.

¶14:

¶15: As in the earlier Intifada, children are the main catalyst to express resistance to occupation and rallying of a national Palestinian identity. They may contribute to sensationalizing the plight of Palestinians in the international media, but the heavy toll on their lives and injuries they sustain are the price that is paid.

¶16: Despite massive efforts and very high level talks among Israeli and Palestinian political elites since 1993, the promised "dividends" of the peace process have not been translated into concrete results for the majority of the people. In fact, living standards have worsened since "Oslo". The population continues to rise, the economy and the environment worsen, and Israeli settlements have continued to expand, against international resolutions and law condemning this illegal practice. The disillusionment of the masses is related to their feelings of disenfranchisement from this high level peace process, and disempowerment in the face of life under Occupation. Palestinian society, especially youth, feel that the future is bleak, and it continues to venerate martyrdom, much facilitated by the Intifada.

¶17:

¶18: The international community has been flooded with urgent appeals to support the Palestinians through this difficult crisis. Calls for international protection, medical aid, food, shelter and water continue to pour in. CIDA continues to seek ways in which Canada can demonstrate solidarity with the Palestinians by supporting their urgent needs, all the while ensuring that our investments are strategic and contribute to longer-term development. CIDA has been asked to support efforts towards the psycho-social and physical well-being of children traumatized by violence. These children are future leaders of Palestine (should a State ever be declared). Contributing to this area could not only allow CIDA to respond to urgent needs, but also allows us to invest in the long term well-being of the future generation of Palestinians.

¶19:

¶20: Current Situation - The Palestinian Ministry of Planning and International Cooperation (MOPIC)'s Secretariat for the National Plan of Action for Palestinian Children prepared, prior to the current outbreak of violence, a national action plan to improve the quantity and quality of integrated, preventive and community-based psycho-social and mental health services. This action plan identifies actions and needs, required resources and roles of the different service providers (Government ministries, Universities and NGOs) currently involved in developing and providing mental health services to children and their families. The action plan is a first step on the way to developing, with partners, a national policy and co-ordinated actions to address the psycho-social needs of children throughout West Bank and Gaza. Partners have all agreed to this approach, recognizing the value of an integrated system. However, resources are needed to implement the action plan and assemble fragmented and inadequate services for community-based prevention of mental health problems.

¶21:

¶22: Since the Al Aksa Intifada emerged, mental health needs have snowballed, especially for the children who do not have the emotional maturity to deal with omnipresent violence and fear. We were surprised to learn that there is a painfully low number of qualified, specialized professionals in the area of mental health in the Palestinian Territories. There are less than 20 psychiatrists, 15 psychologists and 100 professional social workers for over 2.3 million people, including over one million children. To compound the problem, most of these services are not readily available in rural areas. Everywhere, there is a lack of community-based crisis intervention services that can reach out to families with basic counselling and guidance in times of dire need. When one considers that the Palestinian population is growing 5% larger every year (the Gaza strip has a fertility rate of 7.1!), ignoring the inadequacies and inefficiencies of the current "system" could be catastrophic.

¶23:

¶24: CIDA sees a clear need, currently unfulfilled, to play a role in supporting the national action plan, focussing on urgent needs related to psycho-social and physical trauma and prevention in the longer term. CIDA could contribute towards efforts to co-ordinate and integrate actions, towards one coherent national strategy that effectively empowers Palestinians with the skills and

knowledge to increase childhood resiliency and proper childhood coping and development strategies.

¶25:

¶26: Description - The Middle East Programme wishes to launch a new iterative programme to support the physical and social well-being of Palestinian children. CIDA's contribution will be to facilitate co-ordination and co-operation across agencies and to improve their delivery of services in the area of psycho-social and physical support services to Palestinian children, their families and their communities.

¶27:

¶28: Within the iterative design process, CIDA envisages a two phases approach. The present PAD is for the first phase only. Phase I is comprised of two main components.

¶29:

¶30: The first component of Phase I will address the immediate urgent needs of Palestinian children by supporting four or five local NGOs that will provide them with psycho-social counselling and physical rehabilitation. Financial assistance totalling \$700,000 for outreach programs, such as those being implemented by the Gaza Community Mental Health Centre and other Palestinian NGOs, will be provided in order to help these organizations supply the increased need for services. Selection criteria will include the following:

¶31:

¶32: Demonstrated technical and administrative skills of the organization

¶33: Target populations (children, their families and communities)

¶34: Methods and approaches that are sensitive to gender differences

¶35: Reputation within the community serviced by the organization

¶36: Past performance

¶37: Long-term commitment to helping traumatized children

¶38: Relevance to the National Plan of Action for Palestinian Children

¶39: In-kind or financial contribution of the organization

¶40:

¶41: A more complete set of criteria will be developed by a selection committee to be established and led by the Canadian Representative Office in Ramallah. The selection committee will comprise the HOA and the CIDA programme officer in the field, the coordinator of the National Plan of Action for Palestinian Children and Oxfam-Québec.

¶42:

¶43: The second component of Phase I, costing about \$100,000, involves the drawing up of terms of reference and contracting of a project facilitator whose role it will be to do an in-depth needs assessment to support the implementation of the national plan of action for Palestinian Children, identifying if there is a need for Canadian value-added. The facilitator's main output would be the participatory development of a programme design that will constitute Phase II. The duration of Phase I, depending on our ability to deliver programming in the current circumstances, would run up to one year.

¶44:

¶45: The exact form and cost of Phase II is not yet known. However, its anticipated aim will be to increase the access children and youth to coping and life skills training and psycho-social or physical rehabilitation as the case may be. CIDA will encourage prevention of long-term negative effects of trauma and the integration of current services. This may require institutional strengthening of key government ministries, namely the Ministry of Education, the Ministry of Health, and the Ministry of Social Affairs. These coping and life skills will give children, their teachers, families and communities the tools to deal with conflict by non-violent means and to deal effectively with trauma. This second phase could run approximately four years. The estimated cost of phase II is not yet known. It will depend on the in-depth assessment of needs.

¶46:

¶47: Phase II could begin as soon as its design is ready and it will not depend on the prior completion of the first component of Phase I.

¶48:

¶49: Expected Results- To be consistent with the spirit of an iterative approach, an LFA was not prepared for this project, because it needs to be prepared with partners in the field. However, the following general results have been established and will be fine-tuned with partners.

¶50:

¶51: Goal : This and future generations of Palestinians have the basic skills to deal with the effects of conflict. Decreased incidence of mental illness resulting from trauma associated to violence.

¶52:

¶53: Purpose : To increase children's resilience to trauma related to violence, by enabling NGOs and other agencies to provide more quality services to them, their families and communities.

¶54:

¶55: Expected outcomes : Palestinian children themselves are more able to cope with trauma; Families and communities are better equipped to deal with their traumatized children in constructive ways; Improved co-ordination and integration of service providers to Palestinian traumatized children, their families and communities.

¶56:

¶57: Outcome indicators : Psycho-social evaluation of children's resiliency and ability to cope with violence; Number of outreach programs; Client/community appreciation of outreach and regular programming; Reports on the implementation of co-ordinated and integrated services; NGO Performance Evaluations.

¶58:

¶59: Outputs : Increased capacity of NGOs to meet the demand for services; Palestinian children and their families have access to quality services for psychological and physical trauma treatment; Community-based and preventive outreach services increased in urban and rural areas; A co-ordinated and integrated programme is designed and implemented by organizations, institutions and ministries involved in providing services to affected children.

¶60:

¶61: Output indicators : Number of clients served (disaggregated data collected); Improved mental health of Palestinian Children as measured by professional examinations, personal assessments and assessments by families and communities; Satisfaction of clients; Successful integration and participation of physically and psychologically traumatized children in society; Financial investments; NGO performance evaluations.

¶62:

¶63: Beneficiaries - The programme's main beneficiaries are children (up to 18 years of age) and young adults (up to 30 years), their families and communities. A co-ordinated approach within the National Plan of Action for Palestinian Children will maximize resources and the effectiveness of service providers' concerted actions. Palestinian society, it is hoped, will also benefit from this initiative due to a healthier and more resilient population, better equipped resolve problems without resorting to violence.

¶64:

¶65: Links to Canadian ODA and CIDA priorities - This initiative supports human security in the Middle East by addressing a critical factor, childhood trauma as a contributor to a culture of violence. Its beneficiaries are Palestinians, the focus of Canada's development assistance. The initiative is also consistent with CIDA's programming priorities for the Middle East, including capacity building as well as support to peace. Finally, it is in line Canada's leadership role in protecting war-affected children, one of the four priorities of CIDA's Social Development Agenda.

¶66:

¶67: Risks and mitigation strategies - Aside from the obvious risk that armed conflict and closures pose to the delivery of development and humanitarian assistance in the Palestinian Territories,

there is little risk associated to the proposed iterative, two-phase approach. The Palestinian partners are all well known to CIDA. More precise selection criteria will be developed to ensure that each contribution goes towards clearly defined and measurable results. (An existing proposal assessment tool (Application for Project Funding Assessment) will be adapted to the needs of this new initiative. Each assessment will be approved by the selection committee, and scheduled disbursements will be made thereafter. A local auditing firm will be hired to ensure that contributions to the four or five Palestinian NGOs, under Phase I, are efficiently managed.

¶68:

¶69: Consultations - The Palestinian Ministry of Planning and International Cooperation (MOPIC)'s Secretariat for the National Plan of Action for Palestinian Children, Ministry of Education, the Gaza Community Mental Health Centre and Oxfam-Québec and the Canadian Representative Office in Ramallah have all been consulted and agree with the proposed iterative approach.

¶70:

¶71: Estimated cost and duration - Phase I will run up to one year and cost \$800,000. Phase II will run four years, but it is too early to estimate a budget.

¶72:

¶73: Management and contract plan - If this proposed programme and phased approach is approved, CIDA will immediately form the selection committee based in Ramallah, and review proposals from Palestinian NGOs providing psycho-social and physical rehabilitation services to children, including a contribution up to \$300,000 to the Gaza Community Mental Health Centre. Each proposal will be assessed according to criteria and a letter of agreement will be signed with each NGO. Contributions will be approved at the appropriate level of authority in CIDA, according to the parameters set out in this PAD. HOM will be accountable for the sound management of CIDA funds, and will ensure that regular financial and progress reports are submitted on time to CIDA for review. In co-operation with the selection committee, the project team will develop terms of reference for a project facilitator, to be hired on a competitive basis. A contract for services will be signed with the selected facilitator.

¶74:

¶75: It is too soon to speculate on the management and contract plan for Phase II.

¶76:

¶77: Line of Business - The suggested Line of Business is the Iterative Model (L.O.B. 5)

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