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1. Background

Psychological suffering is the most enduring consequence of war, human rights violations such as torture, and natural or human-generated disaster. The psychological consequences can profoundly impact a person’s ability to function and return to a meaningful, productive life within their family and community—thereby altering an entire society’s capacity to recover, rebuild, and reestablish peace.

Due to traumatic refugee experiences, many refugees and asylum seekers face an elevated risk of developing mental health problems such as post-traumatic stress disorder, suicidal intentions, depression, anxiety, and cognitive difficulties. According to the WHO, over 50% of refugees have mental health problems (http://www.who.int/hac/techguidance/pht/mental_health_refugees/en/). Unaccompanied minors, children, orphans, former child soldiers, women and girls as well as survivors of torture and sexual harassment are particularly prone to developing mental health problems. The distress that refugees and asylum seekers experience being in a country that is not home, without guaranteed rights or security, compounds this issue.

The mental health needs of refugees are often not recognized as a priority and it is almost impossible for refugees and asylum seekers to access mental health services in Southeast Asia. Most national civil society organizations lack the specific skills, knowledge, and experience necessary to meeting these needs. Further specialized training, knowledge, and resources are vital in order to respond to mental health issues effectively. The high prevalence of mental health problems among refugees, combined with the lack of knowledge and experience to address these issues, highlights the importance of this training initiative.

Training Objectives

1. To build knowledge, skills and capacity among organizations working with refugees to respond more effectively to mental health issues among refugee populations
2. To improve coordination between service providers for refugees in order to develop a more holistic approach to refugee mental health and well-being
3. To provide a platform for sharing of experiences, challenges and best practice
4. To develop concrete actions plans on refugee mental health to be taken forward in 2012-13

APRRN anticipated the following outcomes for this training:

- Development of skills, knowledge, and resources on refugee mental health among APRRN members, relevant to their work on the ground
- Increased information sharing on refugee mental health among APRRN members
- Recognition of refugee mental health as a critical issue that needs to be addressed
- Increased cooperation and collaboration amongst organizations working on refugee mental health issues
2. Description

This capacity building initiative was a joint effort led by APRRN Southeast Asia Working Group and Burma Border Projects (BBP), a non-profit organization dedicated to the mental health and psychosocial well-being of the displaced people from Burma. BBP's programs address the psychosocial consequences of trauma associated with human rights abuses and dislocation of Burmese refugees.

This initiative’s strategy is to build local capacity in each national community to be able to provide for the most vulnerable among them—refugees. Refugee service providers are all collaborating through this endeavor to better identify gaps and find strategic solutions that benefit the refugees we serve.

UNHCR and some NGOs provide counseling to refugees, but the services are usually limited and ad hoc. Many frontline staff are expected to deal with traumatized people on a daily basis, without the appropriate training to do so. There are few mechanisms in place to help such staff cope with the associated emotional fatigue and strain of working with victims of torture and traumatized individuals. This training served the dual purpose of raising awareness for the refugee plight and equipping aid workers with the skills and sensitivity needed to work with these traumatized persons. This initiative’s strategy was also to build local capacity in each national community to be able to provide for the most vulnerable among them—refugees. Refugee service providers are all collaborating through this endeavor to better identify gaps and find strategic solutions that benefit the refugees we serve.

APRRN would like to thank all resource persons for contributing their expertise and knowledge to this training. The training was conducted by Ms. Derina Johnson, a play therapist from Ireland. Ms. Johnson is currently based in Mae Sot, Thailand, developing and supporting community-based child and youth psychosocial services for Burma Border Projects. Other resources persons included Judith Strasser (Transcultural Psychosocial Organization), Sopheap Taing (Transcultural Psychosocial Organization), Ofelia C. Mendoza (Community and Family Services International), Dr. Xavier Pereira (Health Equity Initiatives) and Meredith Walsh (Burma Border Projects). We also want to thank additional speakers, which include Eh Tho (Mae Tao Clinic), Saw Than Lwin (Eh Tho), Yan Seng (Salus World) and Dr. Htin Zaw (Social Action for Women). Special thanks also go to Lucinda Lai from Burma Border Projects, who helped us in preparing the training as well as this report. We would also like to acknowledge all the APRRN staff and volunteers for bringing this training life. Lastly, our thanks also go to our funders, without them the training would have not been possible, they include: OSI, Planet Wheeler Foundation and Oak Foundation.
### 3. Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tr>
<td>Srun Sony</td>
<td>JRS Cambodia</td>
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<tr>
<td>Judith Strasser</td>
<td>Transcultural Psychosocial Organization</td>
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<td>Sopheap Taing</td>
<td>Transcultural Psychosocial Organization</td>
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<tr>
<td>Rizka Argadianti Rachmah</td>
<td>Human Right Working Group</td>
<td>Indonesia</td>
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<tr>
<td>Suarni Daeng Caya</td>
<td>International Catholic Migration Commission (ICMC)</td>
<td>Indonesia</td>
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<tr>
<td>Yunita</td>
<td>Jakarta Legal Aid Institute (LBH Jakarta)</td>
<td>Indonesia</td>
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<td>Zainuddin</td>
<td>JRS Indonesia</td>
<td>Indonesia</td>
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<tr>
<td>Vivienne Chew</td>
<td>Malaysian Child Resource Institute</td>
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<td>Lia/Syed</td>
<td>MSRI</td>
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<td>Katrina Maliamauv</td>
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<td>Dr. Xavier Pereira</td>
<td>Health Equity Initiatives</td>
<td>Malaysia</td>
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<td>Yolanda Lopez</td>
<td>MSRI</td>
<td>Malaysia</td>
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<tr>
<td>Shwe Wutt Hmon</td>
<td>Salus World</td>
<td>Burma</td>
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<tr>
<td>Ye Naung</td>
<td>Salus World</td>
<td>Burma</td>
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<td>Yan Seng</td>
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<tr>
<td>Ofelia C. Mendoza</td>
<td>Community and Family Services International</td>
<td>Philippines</td>
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<td>Sophie Marques</td>
<td>Asylum Access</td>
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<td>Jintana Sakulborirak</td>
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<td>Gaewgarn Fuangtong</td>
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<td>Anada Jindarat</td>
<td>Bangkok Refugee Center</td>
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<td>Anna Nguyen</td>
<td>Boat People SOS</td>
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<td>Nipaphun Torsound</td>
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<td>Sara Baumann</td>
<td>Old Fan Films/ BPSOS</td>
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<tr>
<td>Quesney Buledi</td>
<td>Refugees Education Committee</td>
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<tr>
<td>Dr. Htin Zaw</td>
<td>Social Action for Women (SAW)</td>
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<td>Haemin Park</td>
<td>Thai Committee for Refugees Foundation (TCR)</td>
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<td>Pachara Sura</td>
<td>Karen Department of Health and Welfare</td>
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<td>Terence Shum</td>
<td>Individual</td>
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<td>Wanrob Wararasdr</td>
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<td>Saadia Aleem</td>
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<td>Amit Singh</td>
<td>The United Nations Office of the High Commissioner of Human Rights</td>
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<td>Saw Than Lwin</td>
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<tr>
<td>Lucinda Lai</td>
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<tr>
<td>Derina Johnson</td>
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<td>Meredith Walsh</td>
<td>Burma Border Projects</td>
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<td>Khin Myat</td>
<td>Myanmar Orphans Support Network</td>
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<td>Lina Djillali</td>
<td>Asylum Access Thailand</td>
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<tr>
<td>Time</td>
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<tr>
<td>9 – 10.30 AM</td>
<td>Day 1</td>
<td>Welcome remarks</td>
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<td>Objectives of the training</td>
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<td>10.30 – 10.45 AM</td>
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<td>Coffee break</td>
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<td>10.45 AM – 1 PM</td>
<td>Day 1</td>
<td>Introduction to refugee mental health:</td>
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<td>- What is mental health? What is the importance of psychosocial services?</td>
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<td>- Prevalence of mental health disorders in refugee populations</td>
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<td></td>
<td>- An overview of common mental health disorders found in refugee populations (depression, anxiety, somatization, psychosis, PTSD)</td>
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<td>1 – 2 PM</td>
<td>Day 1</td>
<td>Lunch break</td>
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<td>2 – 4 PM</td>
<td>Day 1</td>
<td>Panel discussion:                                                     Dr. Htin Zaw (Social Action for Women)</td>
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<td>Different perspectives of mental health professionals from Southeast Asia</td>
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<td>Ofelia C. Mendoza (Community Family Services International)</td>
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<td>Yan Htaik Seng (SalusWorld, Burma)</td>
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<td>4 – 4.15 PM</td>
<td>Day 1</td>
<td>Coffee break</td>
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<td>4.15 – 6 PM</td>
<td>Day 1</td>
<td>Self-care:                                                            Dr. Xavier Pereira (Health Equity Initiatives)</td>
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<tr>
<td></td>
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<td>- Concepts: compassion fatigue, burnout etc.</td>
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<td>- Predictors of compassion fatigue, burnout</td>
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<td>- Strategies for self-care</td>
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<tr>
<td>Day 2</td>
<td>9 – 11 AM</td>
<td>Trauma:                                                               Dr. Xavier Pereira (Health Equity Initiatives)</td>
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<tr>
<td></td>
<td></td>
<td>- What are traumatic experiences?</td>
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<td>- Difference between stress and traumatic stress</td>
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<td>- Mental health risks (and exposure to trauma) for refugees during the different phases of mobility</td>
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<td>- Consequences of trauma on memory, coping</td>
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strategies, mood state, and disclosure issues
- Why these issues are important in working with/for refugees and asylum seekers
- Benefits of integrating mental health principles and perspectives in legal and social interventions with refugees and asylum seekers

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
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<tr>
<td>11 – 11.15 AM</td>
<td>Coffee break</td>
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<td>11.15 – 1 PM</td>
<td>Mental health programme design</td>
<td>Judith Strasser &amp; Sopheap Taing (Transcultural Psychosocial Organization)</td>
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<td>1 – 2 PM</td>
<td>Lunch break</td>
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<tr>
<td>2 – 4 PM</td>
<td>Break-out session 1: Working with children</td>
<td>Derina Johnson (Burma Border Projects)</td>
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<td>Break-out session 2: Mental health and vulnerable groups</td>
<td>Meredith Walsh (Burma Border Projects)</td>
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<td>4 – 4.15 PM</td>
<td>Coffee break</td>
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<tr>
<td>4.15 – 5 PM</td>
<td>Reporting back from the breakout session and wrap-up</td>
<td>Derina Johnson (Burma Border Projects)</td>
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<td>Day 3</td>
<td>Report back from the breakout session and wrap-up</td>
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<td>9 – 12 AM</td>
<td>Break-out skills session 1:</td>
<td>Ofelia C. Mendoza (Community Family Services International)</td>
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<td></td>
<td>1. Basic skills for service &amp; legal aid providers:</td>
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<td>listening skills, interviewing skills, how to make</td>
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<td>referrals, distraction activities (cultural, physical and</td>
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<td>occupational activities), everyday helping skills, do’s and</td>
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<td>don’ts, the characteristics of an effective helper, working with</td>
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<td>interpreters</td>
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<td>Break-out skills session 2:</td>
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<td>2. Mental health research and evaluation tools</td>
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<td>12 – 1 PM</td>
<td>Suicide assessment:</td>
<td>Judith Strasser &amp; Sopheap Taing (Transcultural Psychosocial Organization)</td>
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<tr>
<td></td>
<td>- Warning signs, risk factors, protective factors, and intervention</td>
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<td>1 – 2 PM</td>
<td>Lunch break</td>
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<td>2 – 4 PM</td>
<td>1. Mapping exercise (to identify and assess beneficiaries,</td>
<td>APRRN</td>
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<td>capacity, challenges, stakeholders and available services in each</td>
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<td>country)</td>
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<td>2. Group discussion session on sharing of experiences, best</td>
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<td>practices, and challenges</td>
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<tr>
<td>4 – 4.15 PM</td>
<td>Coffee break</td>
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<tr>
<td>4.15 – 6 PM</td>
<td>Drafting of action plans</td>
<td>APRRN</td>
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5. Introduction to Refugee Mental Health

Presented by Derina Johnson (Burma Border Projects)

2010/2011 Statistics on forcibly displaced people:
Forty-three point seven million forcibly displaced people around the world, out of those an estimated 80% are women and children. Fifteen point four million are refugees, 837,500 are asylum seekers and 27.5 million are IDPs. According to UNHCR, by the end of 2010, three quarters of the world’s refugees were residing in a country neighboring their own.

Definition of refugees:
A refugee is a person who is outside his or her country of nationality or habitual residence, has a well founded fear of persecution based on his or her race, religion, nationality, membership of a particular social group, or political opinion, and is unable or unwilling to avail himself or herself of the protection of that country or to return there, for fear of persecution (1951 Convention Relating to the Status of Refugees).

Refugees and mental health:
The journey faced by displaced people is often a dangerous one and refugees can find themselves unwelcome in the host country. The trauma of separation from family, leaving livelihoods behind, and language difficulties in the host country are significant stress factors. Other causes for mental health problems are unemployment, resettlement, discrimination and detention. Refugees are ten times more likely to suffer post-traumatic stress disorder (PTSD) than the general population of the resettled country (Fazel et al. 2005). Common mental health disorders were twice as high in refugees (44%) compared with economic migrants (20%) (Lindert et al., 2009).

Stigma and discrimination:
The stigma and discrimination attached to seeking psychological help is itself a further stressor. Misunderstanding of mental health issues and fear of requesting support results in delays seeking appropriate help, distress for the affected person and their family, as well as ongoing social and economic exclusion. Practitioners are therefore also tasked with tackling misconceptions of mental health issues and the variety of assistance available.

Definitions of mental health:
Mental health is the full performance of thoughts and emotions. According to the WHO it is a state of well-being in which the individual:

- Realizes his or her own abilities
- Can cope with the normal stresses of everyday
- Can work productively
- Is able to contribute to his or her community

Mental health scale - we are all at different places on the mental health scale at different times:
Mental illness
Mental illness is a combination of physical, psychological, behavioral and imaging symptoms, with differing degrees of severity. When talking about mental illness, we need to keep the following issues in mind:

- Physical symptoms (aches, pains, weakness, tiredness, sleep disturbance, increased or decreased appetite)
- Psychological symptoms (feeling and thinking symptoms)
- Behavioral symptoms (aggressiveness, increased/decreased talking, withdrawal, self-harm, suicide)
- Imagining symptoms (perceiving or experiencing things that are not actually real)

It is important to distinguish between mental health issues and, for example, learning difficulties or the incomplete development of mental capacities which can be present from birth.

Stress is defined as a reaction to a difficult or challenging situation, unpleasant event, or harsh living conditions.

Post-Traumatic Stress Disorder:
Diagnosis is a multistep process and it is important to identify, understand and support, NOT to treat.

The important role of those working with at-risk people:
- Recognize when people in their community are experiencing mental health difficulties
- Respond appropriately to people experiencing mental health difficulties
- Refer for appropriate care
- Support people and their families
- Promote mental health awareness within communities
Mental health disorders:  
The most common mental health disorders are depression, anxiety, and drug and alcohol abuse. Severe disorders are psychotic episodes, PTSD and schizophrenia.

Signs of depression include overwhelming sadness, appetite change, weight loss/gain, decreased energy, tiredness, loss of interest, recurrent thoughts of death or suicide plans. Depression has three levels: mild, moderate and severe depression.

Anxiety is common in many people and is linked to real events. Physical symptoms include shortness of breath, tightness in the chest, sweating, shaking, trembling, dizziness, muscle tension and other physical disorders. Help is needed when people cannot lift themselves out of depression or anxiety.

Alcohol/substance abuse: Drug or alcohol use itself is not a sign of mental illness, but abuse is. People with alcohol and drug problems often have underlying mental health problems and use alcohol or drugs as a type of self medication. The issue is very sensitive because people often deny substance abuse and rarely seek help. There is also a lot of guilt and shame surrounding alcohol abuse.

Severe mental disorders include:
- Psychotic episodes: characterized by delusions, hallucinations, loss of contact with reality and bizarre behavior. It may develop into schizophrenia.
- Schizophrenia: inability to tell your own thoughts, ideas & perceptions from reality
- Psychosomatic disorders: A physical illness that is thought to be caused or made worse by psychological factors
- Self harm (a coping mechanism and not a suicidal behavior) and suicide

Gender based violence (GBV):
GBV is any harmful act perpetrated against a person’s will, based on socially ascribed differences between males and females. The form of violence can be physical, sexual, harmful traditional practices, socio-economic, emotional or psychological. Children witnessing violence are also often traumatized. The cycle of domestic abuse:

Cycle of Domestic Abuse

- Oppression
- Poverty
- Unemployment
- Fleeing country
- Loss of man’s role
- Power over family
- Seek control & power
- Men ashamed & afraid
- Violence: physical / verbal / emotional
- Children witness
- Boy: learns violence, Girl: learns to accept violence

Derick Johnson  
CHiMi Youth Psychosocial Services


**Reproductive mental health:**
Mental health of mothers impacts the unborn baby or infant as well as the development of the child later on. It also impacts the mother’s ability to cope with other problems.

**Psychological programs:**
Health and social issues also need to be looked at when designing psychological programs. There is a shift of focus from curing sickness to improving health.

**Psycho-education: Knowledge is power**
- Understanding what stress is
- Understanding what mental illness is
- Facts linked to prior knowledge
- Understanding the value and processes of counselling
- Everyone can relate to mental health difficulties because everyone has them in varying degrees
- Relief is usually the first reaction upon understanding this

**Mental health care programs**
Models differ between:
- Psychological (Psychiatric support, Supportive counseling, Training, Advocacy)
- Social (Practical support, Community education, Community mobilization, Community activities, Advocacy)

**Community and mental health models:**
Resources for community mental health models are often unavailable. In these models, mental health is linked to culture and community and the entire community needs to be involved in care and knowledge. Western models adapted or traditional methods can be used but it needs to be appropriate and effective. According to the WHO, traditional healers are ineffective and do not provide adequate treatment.

Essential to the success of mental health programmes are community ownership and involvement from all levels of that community.

**Mental health techniques:**
- Self help: relaxation techniques, problem solving, exercise, avoidance of alcohol & drugs
- Helping others: psycho-education, listening, empathy and understanding, respect, and no discrimination

**Supportive behaviors for someone with mental health difficulties:**
- Clear and direct communication without being critical or angry
- Allow the person to take some responsibility for their own decisions
- Give the person space when needed
- Remain calm
- Be willing to talk about the person’s problems and possible solutions with them

The heart of counseling includes ears, energy and eyes. Counsellors should limit their own talking, listen and look for feelings as well as facts. They should not jump to conclusions, and ask
for clarification if something in unclear. It is also important to not interrupt the person. Remember to show empathy and imagine how you would feel in this situation.

**Question and answer session:**
Chronic stress affects the brain and creates structural brain changes, which can be irreversible. Intervention is therefore essential. The most common mental health problems among displaced people are depression and anxiety.

. The way you present yourself professionally as a counsellor is the key as well as carefully assessing the situation. Clear communication of the roles and setting boundaries are also important. Counsellors are not “friends” but nevertheless it can be a comforting and supporting relationship. It is better to think of it as a journey that you are going on with the client.

Foreign professionals also need to keep in mind that they will only be there for a limited time. It is therefore effective to link people to others in their own community and establish long term care.

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6. Panel Discussion: Different Perspectives of Mental Health Professionals from Southeast Asia

Panelists: Dr. Xavier Pereira (Health Equity Initiatives), Yan Htaik Seng (Salus World), Dr. Htin Zaw (Social Action for Women), Ofelia C. Mendoza (Community and Family Services International)

Each panelist gave brief presentations of what services their organizations provide, followed by an interactive discussion.

**Dr. Xavier Pereira (Health Equity Initiatives)**
Currently there are about 100,000 refugees in Malaysia, mostly from Burma but also from Sri Lanka, Africa and the Middle East (Iraq, Iran, and Afghanistan). Refugees and asylum seekers are regarded as undocumented and “illegal” by the Immigration Act. They do not have a formal right to work and their children cannot go to school. Female refugees are prone to violence and harassment.

Health Equity Initiatives (HEI) started training health workers in 2008 under the UNHCR program. Community-based people were trained and then went back into the community to deliver mental health programmes. The aim was to make the community aware and more responsible for mental health. In the Burmese community there were 8 health workers, recommended by the community itself. The health workers were trained in stress management, listening, and a Burmese mental health book was created later. The main challenge of coordinating the community health program was the difficulty of reaching the Malaysian refugee population as well as getting referrals. Constant harassment of refugees by police and the RELA was another major obstacle, and HEI provided a small fund for legal assistant and developed a security protocol. There was also poor uptake of services due to perceptions of what mental health is, and clients often wait for illness to become severe. Health workers conducted a mental health screening, which was helpful in early intervention and prevention of more serious issues. Anxiety and depression is most common, while PTSD is less common among refugees from
Southeast Asia. It was identified that medication should be given in combination with counselling and therapy.

The screening found that depression is a significant healthcare concern, and we need educate and raise awareness of the benefits of seeking help such as counselling. One suggestion was to establish an internship programme for medical students to engage with and understand refugee issues early. HEI already has started to develop several links with educational institutions.

**Dr. Htin Zaw, Social Action for Women (SAW)**
Social Action for Women (SAW) was founded on June 25 2000 to assist displaced women from Burma who are in crisis situations after having fled to Mae Sot, Thailand. SAW is based in Mae Sot and was established to support women facing difficulties through the provision of shelter, health, education, rights awareness, counselling, and vocational training for unskilled women. SAW has expanded its focus population to include caring for and educating orphaned children and children of migrant parents.

Among the projects run by SAW, are the Safe House for abandoned babies, the Children's Crisis Center, the Women's Crisis Center, the Health Care House, which is a shelter for women living with HIV/AIDS, a Preschool and High School, the Reproductive Health Program, an Income Generation Program, the Women Talk Program, and a Program against Gender-Based Violence. Green Hope centre, which is the centre for trafficked women and children, was run under the Human Trafficking Program, and the Boarding House which is for the school children. The last two are the Mobile Medical Team Program and Evening Clinic Program.

In late 2010, SAW joined with Johns Hopkins, Burma Border Projects, Mae Tao Clinic, and Assistance Association for Political Prisoners to begin the Mental Health Assessment Project, or MHAP Project. These groups were identified as serving displaced Burmese adults on the Thailand/Burma border who have experienced violence or trauma due to the ongoing crisis in Burma:

  Burma Border Projects (BBP) is a non-profit organization dedicated to the mental health and psychosocial well-being of the displaced people from Burma. Our programs address the psychosocial consequences of the trauma associated with human rights abuses and dislocation of Burmese refugees. We are the only organization on the Thai-Burma border whose primary mission is to provide mental health resources, trainings, and support to strengthen the skills of local community-based organizations and individuals.

- **b. Mae Tao Clinic** [http://www.maetaoclinic.org]
  The Mae Tao Clinic (MTC), founded and directed by Dr. Cynthia Maung, provides free health care for refugees, migrant workers, and other individuals who cross the border from Burma to Thailand. Today it serves a population of approximately 150,000 on the Thai-Burma border. About 50% of those who come to MTC for medical attention are migrant workers in the Mae Sot area; the other 50% travel cross-border from Burma for care.

- **d. Assistance Association for Political Prisoners**
  AAPP reports on the number of political prisoners held by the military regime, and on human rights violations carried out against them in various detention centers, prisons and labor camps and also provides political prisoners with basic necessities such as food and medicine.
MHAP Project Design:
This project is under an award by the USAID Victims of Torture Fund. The faculty from the Johns Hopkins Bloomberg School of Public Health has developed and used a stepwise approach to helping psychosocial programmes evaluate the impact of their interventions. This approach has four elements:
1. Informing program design through the collection of data at the community level
2. Improving implementation through training and supervision
3. Monitoring program activities and addressing problems; and
4. Evaluating impact at the level of the individual.

This approach, collectively referred to as DIME (Design, Implementation, Monitoring, and Evaluation), has been completed successfully with service organizations in multiple countries.

For the study of intervention feasibility and effectiveness, it is necessary to keep several different sets of records:
1. **Participant attendance:** level of individual participation in the intervention program should be recorded throughout the entire process. This is done using the weekly monitoring forms.
2. **Intervention program:** a record of the activities and general content of the intervention program is kept for supervisory and monitoring purposes. During each counselling session, records are kept and allow the supervisors and the research team to ensure that each program is proceeding as planned and that variation between program providers is kept to a minimum.

MHAP Summary:
The project team includes 3 clinical supervisors (full time), 6 counsellors (full time), 10 counsellors (part-time). 436 people have been screened for inclusion into the study to date and 212 people are currently enrolled in the study, the recruitment of clients is ongoing.

To date, 37 controls have completed their wait-period and have received a follow up interview. The majority has requested CBI and the project is working to either have them seen if someone is available or make arrangements for them to be seen as soon as possible. These people (post-wait control) are also having weekly forms and a follow up assessment done.

Gaps and challenges:
The project initially faced challenges with enrollment. Due to continued challenges of potential clients not meeting screening criteria during the assessment, the project team held on-going discussions regarding new approaches to recruitment. The new approaches to recruitment and enrollment proved to be successful and by the end of November 2012, enrollment numbers were up to 53 individuals enrolled in the trial over all. The counselors continued to provide CBI to those enrolled in the treatment group, while monthly monitoring calls were made to those in the 10-week wait-control group.

In addition the community response (“this project is for crazy people”) and the need to build the confidence of counsellors, posed other obstacles. Many clients also have non-counselling needs that the counsellors try to help them with, but this takes more of their time and energy. In some cases they are not able to help with everything and this causes them to feel disappointed.
**Best practice:**
Training and interventions are best approached systematically. Counsellors have said that they feel more comfortable knowing that there are steps for the counselling sessions and that they have a standardized record keeping system. It is also important to adapt the language used with people in the community, to be less clinical and more understandable/acceptable. Clinical supervisors should be available nearly every day to support counsellors because one weekly meeting is not enough to provide supervision and feedback.

Using the monitoring and evaluation forms (baseline and follow up assessments) is useful and necessary to see how the project activities impact clients’ mental health. In addition, though, the weekly monitoring forms are seen by the counsellors as an integral part of their work and provides them with a way to measure progress on an on-going basis. In many cases, counsellors greatly appreciate having systematic record keeping that allows them to track client progress over time; often serving as a source of motivation for them, both in cases where the client is improving or not improving.

**The way forward:**
The MHAP project team is looking at gathering qualitative feedback from clients on their experiences with CBI; including questions about how they feel it has changed things for them, what they have learnt and are able to utilise in their lives now. The project team is working together to develop relevant questions and get this process started. Both SAW and AAPP plan to carry on counselling activities within their own organizations. For example, SAW will focus on applying the skills we have learnt from this project to providing services for our shelter clients, as well as expanding the coverage of services to the Phop Phra migrant area, 40 kilometers south of Mae Sot.

**The imitations of a Western approach of mental health:**
Many refugees in Thailand never receive refugee status and even those that do cannot work legally. They live in dire conditions and face harassment and extortion. This takes a heavy toll on the mental health of migrants, many of whom also bear the burden of past traumas. Several NGOs operate mental health services both in the refugee camps and the border towns. But while many workers from these organizations, and the methods they use, come from the West, some maintain that Western models of mental healthcare are not always relevant to the experiences of people in Asia.

People often make the mistake of trying to impose Western-style mental healthcare, but people based in the region have experienced trauma specific to living in this environment. They will therefore not have the same mental health issues as a Western person, and there are many instances of culturally specific mental health issues in Asia that remain largely unknown in the West.

Then there is the thorny issue of language. Even the most basic Western terms such as ‘depression’, ‘anxiety’ or ‘trauma’, do not translate directly to Burmese. The concept of PTSD is irrelevant to the refugees on the Thai-Burma border – they are still deep in the crisis. The model was based on Vietnam veterans going back to the US and living in a safe community, but refugees here are not in a safe community. It is precisely the ongoing nature of their circumstances that acts as a protective factor against complete mental breakdown. When in
‘survival mode’, people are focused on staying alive, and have little time to dwell on past traumas. Without employment, documentation, or legal status, the obstacles to immediate survival are of primary concern.

Discussion of past traumas is not a priority, and attitudes towards counselling reflect a deep seated stigma attached to mental health issues. The perception that counselling is solely for severe psychosis is preventing the uptake of assistance. Mental health workers in Mae Sot for example would need to adapt their vocabulary and the way in which they frame their methods to encourage Burmese people to use the services.

Accordingly, the practice is not referred to as counselling, and rather than set appointment times, people are able to come into the clinic to talk with a medical profession. While going to the doctor with a mental health concern would be unthinkable to many here, it is far easier to talk to doctors about something concerning the body. The issue is how to increase use of these services by Burmese who need them. If food, security, and other basic needs cannot be met, seeking psychological help becomes a very low priority.

Yan Htaik Seng (Salus World)
Salus World focuses on NGOs workers and provides group counseling for various groups. NGOs inside Burma often focus on counselling for people infected with HIV and also former political prisoners. Resources are scarce, a lot of stigma exists, and there are no supervisors available for counselors. There is also no formal mental health training available in Burma at present.

Ofelia C. Mendoza (Community and Family Services International)
The Philippines are signatory to the 1951 Refugee Convention, and there is more intra-agency collaboration between and among UNHCR, Department of Justice and Community and Family Services International (CFSI). CFSI also collaborates with government services and NGO’s, using the case management approach to the provision of legal and psychosocial support to refugees and asylum seekers. In the Philippines, refugees have access to regular employment and business opportunities, as well as education and vocational training opportunities. They enjoy freedom of movement and access to social and health services.

CFSI use social workers and case managers for their program. Social workers need the ability to identify poor mental health conditions (physical conditions, substance abuse etc.). All the refugee programs at CFSI try to include mental health aspects. Mental health workers have knowledge of the home country of refugees, can assess the case and see coping mechanisms and they must be anchored in a participatory process. CFSI also provides direct intervention and secondary intervention through recreation and training.

Challenges remain however. There are language barriers, integration difficulties, and social workers are not professionally trained like psychologists and psychiatrists. CFSI also encourages self-care of their counsellors.

Questions & Discussion:
In Burma counselling for HIV patients is required before they can get medication.

It is difficult to encourage people to seek counselling – this should not be forced, but rather a journey. We need to teach the importance of mental health care and reach out to communities.
Getting people from the community involved is the key and mentoring has proved successful. Professionals should also not forget that they have a lot to learn from the populations they work with – it should be a bottom up approach. A good way to stimulate interest in counselling is through activities such as group counselling. This is challenging due to diversity among the population, but has potential value.

Confidentiality and consent is the key to any therapy, and counsellors should take written consent. Trust is a huge issue among Burmese refugees, so the guarantee of confidentiality is vital. Mae Tao Clinic has spiritual treatments as well as scientific. MTC staff does not impose prayer but religion is respected. The question however remains how different groups can retain their spirituality as their trauma may have damaged this.

In Southeast Asia, PTSD only seems to be relevant among few Burmese refugees because most of them are more occupied with present issues. It is definitely very common among Sri Lankan refugees due to experiencing torture and witnessing other abuses. Afghan refugees also have high instances of PTSD and so do Iranian and Iraqi refugees.

Recreational activities and community activities are a form of therapy, and this has especially proven to be useful for women who are victims of violence and the LGBT community. Even with language barriers, group therapy was useful in sharing experiences and has worked across cultures. Livelihoods projects for women from different ethnic groups with a common goal have also been effective and had a therapeutic effect. Bringing together communities helps to regain some normality and provides a safe environment. This approach has also worked on the Thai-Burma border for landmine victims. Mentoring programs have worked well for teenagers.

Many strategies can be used for social intervention. Group counselling is not enough and group work has proven to be more effective. Group work and group therapy can also be combined. Mental health workers need to keep in mind that there is a reluctance to talk about many issues in a group setting due to feelings of shame.

Some NGOs report that they have used refugees to help refugees and this was mostly positive. On the other hand, there have also been bad experiences and mental health workers need to be careful when considering this approach.

### 7. Self Care

Presented by Dr. Xavier Pereira (Health Equity Initiatives)

The main focus of this session was self-care and burnout, which poses a risk for many who work directly with refugees. The session also covered “compassion fatigue,” which is experienced by people who work with people.

**Burnout:**
Burnout is related to work and also interpersonal relationships. We might find ourselves doing a lot of work but that might not be productive. Assertiveness is a protective strategy when it comes to burnout. Manifestations of burnout are exhaustion and cynicism.
Some of the issues pointing to burnout:
  o Little or no control over your work
  o Lack of recognition or rewards for good work
  o Are the expectations unclear
  o Do you think that your work is monotonous or unchallenging
  o Chaotic or high pressure environment

Burnout is definitely an issue with people who work with refugees, especially health workers who work within their communities. Trouble sleeping is one sign of burnout.

Work related conflict is another cause of stress, and there is a culture of working long hours in Asia. Type A personalities and high achievers also tend to experience stress and burnout more easily. At HEI there are currently 15 full-time employees, over the time the organization learned to be more selective about which people to take on and personality traits also play a great role.

A stressed person is still active but tense and restless. A burned out person is stressed but also tired and slow. Under stress, the autonomic nervous system becomes hyperactive and symptoms are a fast heartbeat, dilated pupils, hyperventilation and tremors. People under stress also tend to make more mistakes. A burned out person wants to be disengaged from people and emotions become blunted. The person slows down and embraces negative thinking, the sense of hope drops and there is a loss of motivation and ideals.

**Anxiety:**
Headaches are very common and more than 80% of headaches are tension headaches. Relaxation exercises have been proven to be successful because under stress our muscles tense.

**Compassion fatigue:**
Symptoms are usually normal displays of chronic stress resulting from care-giving work. This makes it different from burning out. In Latin compassion means suffering, it is different from empathy which implies that you put yourself in the shoes of another person. Characteristics include deep emotional and physical exhaustion with symptoms resembling stress and depression. Compassion fatigue can happen even if we are compassionate people but if we no longer feel for the people that we are working for. The consequence then is that we become too tired mentally to show compassion anymore. This can also lead to burnout.

**Vicarious trauma:**
“The transformation that occurs in the therapist (or other trauma workers) as a result of empathic engagement with clients’ trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people’s cruelty to one another and witnessing and participating in traumatic reenactments.” (Expert definition: Pearlman LA, Ma Ian PS, 1995)

Mental health work is tiring and requires engagement which includes listening to graphic descriptions of horrific events, which can itself become traumatic. It is important to take breaks from directly working with refugee clients. We also need to be aware of what people we work with are experiencing and what their individual needs are.
The level of compassion fatigue can also vary depending on the workload, the traumatic content of the work and the case load. Individual symptoms include:

- Denial of problems
- Substance abuse
- Suicide – four times more men than women commit suicide and four times more women than men will attempt suicide

Symptoms at the organizational level:

- High absenteeism
- Constant changes in co-workers relationships
- Inability to meet deadlines
- Lack of flexibility among staff members
- A lot of negative feelings toward management
- Reluctance towards change

Despite good skills and good work, this behavior can be detrimental to the organization and teamwork. Therefore the management has to consider how best to proceed.

The path to wellness starts with self-awareness. Activity for self-awareness:

- Get one piece of paper. Fold into 2 equal halves and tear along the line.
- Write down your name on top of both pieces of paper.
- Put the numbers 1-5 on both pieces
- Inventory of strengths: On one paper write down what you possess that are assets or strengths. Write 5 good things about yourself. If your esteem is high, you can turn the paper over and write 10 good things about yourself.
- Bring your right hand up and tap on your other should and say: I AM GOOD
- Turn to the person next to you and say: YOU ARE GOOD
- Ask 5 people to write one good thing about yourself on the other sheet of paper and then compare both sheets
- The Johari Window: the strengths that other people see in you, those that only you know about, and those that others noticed but you did not
- Affirmation is important and a lot of healing comes with affirmation, remember that the people we work with have not been affirmed. If you are having difficulty filling up the sheet, you need to ask yourself, why?

Another exercise:

- Take a clean sheet of paper
- Draw a symbol, simple picture, or a word that represents your work related to refugees
- Share this with others
- It’s so important to be aware of our thoughts, feelings, and behaviors.

The cycle of change:

1. Pre-contemplation
2. Contemplation
3. Preparation
Erik Eriksen - Psychosocial stages of development:

- ADOLESCENCE
- YOUNG ADULTHOOD
- MIDDLE ADULTHOOD

From adolescence to young adulthood, we need to achieve identity, intimacy, and giving. If this is not achieved it can result in confusion and isolation. We need to look into ourselves and ask if work defines us or if we define our work. If you sense an uneasiness or discomfort, then maybe your work is defining you. That can lead to burn out and compassion fatigue. It also means that you are unable to extricate yourself from what you do. Your whole self is what you do.

The psychosocial tasks in early stages of development are autonomy and trust. We often lack control when we are younger and are subordinate to people. Greater autonomy then comes with middle adulthood and there is less stress in this stage.

Stress management:
In order to reduce stress, we need to organize ourselves and set priorities. It is often useful to create a list of all the tasks you have and also delegate. Organizational stress management can be managed in the following way:

- Thorough selection of new hires
- Orientation as opposed to letting them learn the ropes by themselves
- Connection: not feeling connected to the organization can lead to stress
- Assimilation: The person should feel that he or she belongs to the organization
- Participatory management: less stressful than a hierarchical style

Self-care steps:
- Work Life Balance: write down how many hours you work and reflect on this
- Sleep hygiene
- Leisure and relaxation: meditation and yoga
- Physical exercise

Exercise: Social support – “The circle of intimate relationships”
- Make 3 concentric circles (Inner circle: Wife, children, parents etc., Second circle: friends, siblings, in-laws etc., Third circle: Colleagues and staff, other people)
- How many of them can you turn to when you need support? How does this make you feel? Also ask yourself if these people are available when you need support?
- People who are negatively connected to you can be put on the outside of the biggest ring

8. Trauma and memory
Presented by Dr. Xavier Pereira (Health Equity Initiatives)

Among refugees in Malaysia, loss is an issue and experienced by many. There is also a lot of insecurity, threat and then of course TRAUMA. We need to distinguish between traumatic events and stress. Traumatic stress comes from a traumatic event and the amount of traumatic stress varies from person to person according to resilience. The person who is resilient has a less
severe response. Trauma can be experienced directly (maybe of our refugee clients are wounded, threatened with death, subjected to gross human rights violations, including torture, have lost a lot, or are confronted with actual fighting). People can also experience trauma by witnessing traumatic events. Refugees have often witnessed torture, sexual violence, rape, killings, and have seen dead bodies (mutilated) or have heard stories of traumatic experiences.

Case studies:
#1: Sri Lankan Tamil refugee: A psychiatrist diagnosed him with PTSD. He had tried to fight against minister who wanted to take over his family’s land. They poured gasoline over him and threatened to burn him, and he feared for his life. He went to the UK but was deported and is now waiting for his RSD interview.
#2: Karen refugee: He did not experience trauma directly, but the language he used and his nightmares were symptomatic of PTSD. During the clinical interview, it was discovered that he had witnessed his parents being killed and his relative being burned alive in 1997. Because of that, he refused to speak the Burmese language. This case shows how witnessing a traumatic event can also lead to PTSD.

Traumatic stress affects thinking, feelings, behavior, and there are many physical reactions to stress. The difference between traumatic stress and general stress is that traumatic stress comes from a traumatic event: traumatic event + stress = trauma. In the pre-migration and post-migration process the following stressors can occur.

Pre-flight: Economic hardship and poverty, Disruption of social relationships
During flight: Hazardous journey, Sexual violence
Post-migration:
- Temporary settlement or asylum seeking
- Access to health care
- Language barriers
- Financial problems
- Legal recognition
- Access to services and assistance
- Fear and loss

Resettlement:
- The process itself is stressful
- Assimilation
- Cultural adjustment
- Language barriers
- Repatriation: adjustment problems

Psychosocial issues are critical to RSD (refugee status determination) because the greater the severity of the trauma, the greater the difficulties in sharing trauma histories in RSD which can affect the content of the testimony. Retelling trauma can also lead to re-traumatisation.

How well the refugee can present the story depends on several predictors such as memory functioning and coping strategies. The mood state and underlying morbidity are also important. If there is anxiety and depression present, testifying will be difficult and it will affect the quality
of the testimony. Interviewers should be aware that the person has gone through very traumatic life experiences and provide a helping and supportive environment.

**Memory:**
The memory is a cognitive (thought) function and there is a relationship between memory and emotion. Under stress we tend to remember less, but emotionally charged memories are easier to retrain. Reinforcement helps to achieve consistency. Processing of remembering involve registration, retention, and recall. The memory has two components: verbal and imagistic. When a memory is registered it is held as a verbal narrative with a beginning, middle and an end. Research shows that people who are traumatized remember in snapshots, with little verbal narrative holding events together. The RSD process tries to get at the “objective truth” but there is subjectivity, difficulty remembering trauma, and also cultural misinterpretation.

A study by McNally, Clancy, Shacter, and Pitman (2000), found that trauma produces memory blocks. A study in the UK (Herlihy) showed discrepancies in peripheral rather than central details. Memories of traumatic events such as torture can be incomplete. Sometimes we get distracted by the inconsistencies of peripheral details and think there’s something wrong with the retelling. Trauma also distorts perception of time and space. One of the coping strategies we use is avoidance (a deliberate and conscious coping mechanism) by either suppressing (unconscious mechanism) or oppressing (conscious mechanism). Dissociation is an unconscious coping mechanism that leads to disintegration of functioning of identity, memory, consciousness and perception of the environment. The emotional state of refugee affects trauma narratives and that is why there are often two different accounts of the same incident by a refugee. Trauma can also lead to shame and non-trust. Thus there are problems in disclosure (Non-disclosure, delayed disclosure, partial disclosure). The emotional impact of the disclosure affects the narrative. Torture specifically targets the social bonds of trust. In an organized state violence the purpose is often to prevent people from trusting each other (e.g. Myanmar and Sri Lanka).

RSD environment: research shows that interviewer qualities emerged as the strongest factor in either facilitating or impeding disclosure.

Case study: A Chin asylum-seeker had paranoid thoughts and hallucinations. He was denied refugee status and his registration was suspended by UNHCR. This was very stressful for him; the RSD failure led to psychosis.

In the context of exile, detention is another scenario which can lead to a chronic state of fear and apprehension and a general feeling that no one can be trusted. It often comes along with psychotic symptoms and chronic impairment in concentration. It is important to consider psychological factors that impact trauma narratives because it will lead to a more effective assessment of applications by decision makers. This is the benefit of the legal-mental health approach.

**Question and answer session:**
- In the case of Tamil Sri Lankan refugees retelling their stories of India, it took a lot of time to get the stories because they were affected so much by trauma.
- The level of relationship to a given experience also affects the memory.
- The problem with RSD is that they try to establish truth objectively but imagination plays a role and deforms the truth. The truth should be established more through the emotional state rather than the objective details.
• Study in UK on Sri Lankan Tamils: The expression of traumatic experiences is also cultural. In South Asian culture, people often don't look into the eyes of the speaker, and an interviewer will treat this as suspicious. A study in the US has shed light on different communication behaviors among Asians.
• It can be traumatic to look at the narrative and can lose its emotional impact.

9. Mental Health Program Design
Presented by Judith Strasser and Sopheap Taing (Transcultural Psychosocial Organization Cambodia)

History: During the Khmer Rouge regime (1975-1979) nearly 2 million Cambodians died by execution, starvation, exhaustion from forced labor, malnutrition or torture. A radical social transformation back to Cambodian traditional society (agrarian communism) took place and mass deportations, forced labor, torture, imprisonment and brutal executions against perceived “enemies” were common.

Mental health challenges in post-conflict Cambodia:
A nationwide survey shows (2007, Sonis) that 11.2% of the overall Cambodian adult population presents with Post Traumatic Stress Disorder (PTSD). Another a study with non-random sample of direct victims of the Khmer Rouge (2008, Stammel) showed that 14% suffer from PTSD, around 30% of depression and 37% of anxiety. A nationwide survey done in 2010 (2010, Pham) showed that 47% of the respondents felt uncomfortable living in the same community with former Khmer Rouge. 64% stated that they have not forgiven former Khmer Rouge members. High levels of individual and collective traumatisation are still present in post-conflict Cambodia, in addition to fragmentation of the social network, mistrust and feelings of revenge.

Mental health service development:
There was one Mental Health Hospital which was built in the 1960s and located outside the city. There were 2 psychiatrists (trained in France) and no more than 800 occupancy beds. In 1975, the Khmer Rouge turned this hospital to a re-education camp (similar to prison). Some patients were sent out and others were killed. The two psychiatrists were killed, along with other health staff. In 1979, the Khmer Rouge regime collapsed and other health services were rebuilt, but not the mental health service. In 1994, a first ever psychiatric training program was set up by Oslo University from Norway to train the first ten psychiatrists in Cambodia. Since then, there are more than 40 psychiatrists & around 60 psychiatric nurses covering 14 million people in Cambodia. Many NGOs have also started their programs since 1994 (after general election in 1993).

Today there is still a narrow range and limited quality of public mental health services, particularly in rural areas. Services are fragmented as there is a lack of multi-sectoral approaches to mental health care. In addition, there is limited capacity to raise awareness at the policy and legislative levels and ongoing struggles to secure funding.

Transcultural Psychosocial Organization Cambodia:
Vision: Cambodian people living with good mental health and achieving a satisfactory quality of life.
Mission: To improve the well-being of Cambodian people with psychosocial and mental health problems, thereby increasing their ability to function effectively within their work, family and community lives.

TPO’s approach is psycho-social (taking into account the social, cultural, political and medical dimension of mental health); community-based, participatory, human-rights based and combine local and Western concepts. In 2011, TPO teams worked in 12 villagers in two provinces and provided psycho-education to approximately 1,488 villagers. TPO staff in collaboration with key resource persons set up 159 self-help groups (109 of whom were women) and TPO counselors provided individual counseling to 83 people.

Amongst Cambodian people there is still a lot of prejudice of against mental health. TPO has used posters to try and educate people on mental health as well as classes and radio programs. TPO also educated people on the consequences of alcohol abuse/addition. Counselling is done one on one in the office or in the client’s home.

TPO adjusted the program several times to achieve greater effectiveness and sustainability. To improve well-being of target groups sustainably, greater focus on livelihood improvement was necessary. Therefore TPO also set up vocational training and micro credits through local partner NGOs.

Over the years TPO has encountered a variety of challenges:
- Unsustainability due to short-term commitment of donors.
- Fragmentation of services due to donor’s divergent interests.
- Poor collaboration and commitment among partner NGOs.
- Lack of well-trained human resources.
- Labor migration in Cambodian communities due to poverty.
- Target groups have very limited knowledge of mental health as well as access to health and social services in general.

Lessons learnt:
1. Invest into monitoring and evaluation
2. Advocate for mental health and human rights
3. Funding: It is important to engage donors into core funding and have a diversity of donors (UN, EU, bilateral donors, churches, private donors, foundations, etc.). NGOs can outsource proposal writing to experts. Other means include creating income through trust funds and investing more into PR.

Question and answer session:
Funding: TPO deals with funding problems by having a variety of donors and trying to generate income. But it is difficult to get donors to buy the whole basket as opposed to make them fund specific projects. NGOs also need to do a better job communicating with donors.

People in Cambodia rarely talk about the past genocide, and there is evidence that trauma is transmitted to the second generation. The Khmer Rouge regime led to a fragmentation of the social network. After the genocide in Rwanda there were local methods to bring about reconciliation and justice which didn’t work very well, as people still want to take revenge on past persecutors. In Cambodia the past has largely been ignored per government policy. The
tribunals came about as a compromise. Perpetrators and victims had a chance to meet together in person. Psychosocial approaches are often based on human rights and most methods have incorporated a human rights approach. But in Cambodia there is a reluctance of NGOs to take up human rights issues because of fear of the government. With the experience of the tribunal, trust has been gained and TPO feels it can be more visible and will soon launch a report.

Restorative justice model in New Zealand and Australia have been tried among first nation’s people and this has been very successful. In Cambodia, the question remains how do you address poverty, especially mass poverty? Cambodia is a good example of why development aid does not work. After investment of billions, poverty reduction is small and there is no consensus among the development community about what approach works. Now there is so much diversity of programs, agendas, and opinions and it is difficult to control the setting and engage other partners to deliver an integrated approach. That’s why networking with other organizations is key. The community workers can deal with the mental health of the community and can create spin off benefits such as self-confidence to get out of poverty.

NGOs don't provide integrated services typically. In countries like Myanmar, a number of groups have a difficult time coordinating among each other. We also need to think how to encourage governments and donors. Procedures often become donor dependent and not learning with the communities.

Creation of dialogue is important. In Malaysia, different ethnic groups have learned to work together. Mental health is often marginalized apart from regular health fields. It would be good to start networking. In Mae Sot, there have also been efforts to develop a sense of community by looking at similarities rather than differences (for example through sport). We also need to be careful not to isolate one group from other groups. For example: It is difficult to get the Rohingya and Rakhine groups to work together, so the Rohingya have often been excluded.

10. Monitoring and Evaluation Tools

Presented by Judith Strasser and Sopheap Taing (Transcultural Psychosocial Organization Cambodia)

This session introduced some of the tools that TPO has developed in the past year to monitor and evaluate their programs. Monitoring and Evaluation is important:

- To track program implementation and improve/adapt the program while implementing
- To show if you can meet the objectives of the program
- To document good practice
- To stay accountable to donors and beneficiaries, many NGOs in Cambodia think that they have to do it only for the donor. Then M&E becomes a burden.
- Monitoring and evaluation can also be used for organizational learning and practice
- Monitoring and evaluation is in direct line with planning. It should take place throughout the whole lifetime of a project.

Planning: Planning means setting goals and intended results of the project and developing strategies for implementation of the project.
**Monitoring:** Monitoring is the collection, analysis, reporting and use of information about the project’s progress and initial impact. Monitoring should focus on:

- Creating baseline data to which you can compare the progress of your project/program (thus the need for baseline assessments)
- Gathering of systematic feedback from target groups to project activities
- Records (database) of activities, service delivery, organizational and local capacity building
- Budget and expenditure
- Response of the target group—change in knowledge, attitude and practices
- Reasons for any unexpected or adverse response by the target group;

Evaluation is different from monitoring as it has a broader scope. It looks at the impact level and if the overall goal of the project was achieved. It includes all aspects and covers the full program. Usually it is done every ½ year as well as at the end of the project. It involves multiple evaluators. It is sometimes required by donors like the EU. The results can be used by policy makers and not only by managers.

**Results framework:** The results framework has 4 components: activities, outputs, outcome and impact. Ideally, activities directly lead to specific outputs; specific outputs contribute to the outcomes, which can directly lead to the impact of the project. The activities part is guided by the question, “How do we do it?” (For example: For SGBV, do we organize self-help groups, radio broadcasting, etc?) Outputs and outcomes are related to the question, “What do we want to achieve?” The impact component is guided by the question, “Why do we want to change it or do it?”

Outputs vs. outcomes: Some donors require you to define outputs, some don’t. Outcomes are more important for donors because it is closer to the overall impact of the activities.

*Example:* Organize public awareness raising in the communities about GBV

- Outcome: increased knowledge about GBV
- Impact: changing attitudes, increase knowledge, changed behavior → reduced violence against women
Logical frameworks start at the bottom with activities (example: production of leaflets about GBV and distribution to the key persons in the community). The output then would be the number of leaflets produced and distributed. Assuming that people read the leaflets, the outcome is increased knowledge about GBV. This contributes to the overall goal of reduced GBV. The indicators point out things about success, for example measuring whether people read the leaflets and understood the message. Log frames can be creative work and can require 100’s of revisions.

**Example from TPO:**
- **Target group:** victims and survivors of gang rape, forced marriage, sexual violence during the Khmer Rouge regime
- **Goal:** to improve access to justice and rehabilitation
- **Activities:**
  - Logistical support so that the women can participate in the tribunals
  - Organizing meetings with their lawyers
  - Organizing workshops about GBV so they can understand the scope of the violence under the regime
  - Organizing self-help groups
  - Trainings about gender sensitivity

**Exercise: Making a log frame**
For each activity, try to formulate the outputs and how those outputs contribute to the outcome. What could be the possible outcome of this psychosocial activity? Be creative. Try to make all the mistakes that you can do.

Normally, you define the impact first then you think about your interventions and what kind of activities could help achieve this impact. In the example mentioned before, TPO conducted a wide range of interventions:
- Training of judicial staff of the tribunal about gender sensitivity and how to integrate female survivors in the judicial process
• Awareness-building amongst community leaders to learn about GBV during the Khmer Rouge, in order to encourage behavior change in women in the community and to make them participate in the justice process
• Creation of a safe space for women even before beginning to talk about things like past experiences
• Legal education about how the tribunal works
• Outreach program to first reach the women through radio and public awareness raising sessions
• Get access to staff of the judiciary, politicians, police and community leaders
• Provide logistical support to the women to physically access the courts

**Indicators:**
Defining indicators that are measureable is an art. Indicators should be SMART (Specific, Measurable, Achievable, Relevant and Timely). *Example:* How to measure the impact of a nationwide radio program broadcast to all provinces about GBV in Cambodia?

- Radios don’t have statistics about listeners
- Limited budget to survey everyone in the country
- If we just survey SHG’s, then this is not representative
- SMART indicators are needed: specific targeted to slum populations

Cambodia changed the radio show to a call-in show and documented callers’ comments to see if their comments improved their awareness of GBV over time (2 years)

**Quantitative indicators** are statistical measures that measure results in terms of numbers, percentage, rates and ratios. Example: Number of SHG’s formed and the number of women attending + manual has been developed by the women themselves.

**Qualitative indicators** reflect people’s judgments, opinions, perceptions and attitudes towards a given situation or subject. They can include changes in sensitivity, satisfaction, influence, awareness, understanding, attitudes, quality, perception, dialogue or sense of well-being. Example: Women have shared personal experiences openly. 80% of participants disclosed personal information openly in their life (a good direct output of your activity). 20% of the participants decided to take legal action by filing a complaint.

Most donors don’t like numbers at an output level. Most donors want output levels changing knowledge, attitudes, and behavior in your target group. There has been a shift in the donor community from results-based to impact-oriented and a strong demand to be able to report on impact rather than quantitative results. Example: increased solidarity amongst GBV survivors, increased self confidence in talking about what happened to them, increased sense of belonging, increased motivation to access the legal justice system/seek legal aid.

Question: How to measure improved wellbeing?
- Sleep patterns and protocol of disclosure of information

How to measure improved mental health?
- Self-report: Standardized clinical questionnaires
- Reports by significant others
- Case studies – documenting progress over a year
You can have qualitative and quantitative indicators. With mental health and psychosocial activities, we’re mostly talking about qualitative indicators.

Example: we chose two indicators,
- A standard clinical tool (Hopkins 25) because we have used it hundreds of times.
- Case studies: we chose one woman in each SHG and documented her progress over time.

This was the set of measures we used to show whether or not we achieved our outcome.

**How to gather data?**

For individuals:
- Interviews (Structured, Semi-structured, Standardized clinical interview, Ethnographic interview)
- Harvard trauma questionnaire
- PTSD checklist (was developed for Asian populations, validated for various countries, and shown to be consistent
- Question checklists
- Observation (TPO staff reports of how they perceive the group. To see how the group as a whole has evolved)
- Case studies
- Stories (TPO asks people to write up their own success stories about how they, from their own perspective, have seen their progress)
- Body map

For groups and communities:
- Focus group discussions
- Social needs assessment
  - Key informants: Village chiefs, commune chiefs, monks, traditional healers
  - The history of the village
  - A map of the risks and resources
  - Give the results to the village for ownership of the information
  - Write a report to the commune chief to have a document about the village
- Observation and home visits
- Surveys (Example: national survey to explore people’s attitudes towards the tribunals at the beginning)
- Risks and resources map in a community (participatory rural appraisals)

Example: The “Blue Cloth” method: The activity of rating the symptoms is done through a group method to measure the symptoms of individuals. One facilitator is the TPO staff and a community person such as a village chief or an elderly person. It works because the groups are very homogeneous. They all have similar problems and are generally separated by gender. Rural Cambodians know each other well and come from the same community, they also trust each other. It's been a trial and error process to find methods like this that are effective. Feedback from the field into M&E is important.
Specific target groups:
- Children: Rapid child protection assessment form
- Displaced populations in conflict: RAMH – Rapid Assessment of Mental Health Needs of Refugees, Displaced and Other Populations Affected by Conflict and Post-Conflict Situations and Resources

We need to be aware that measuring our work can be a huge task. Staff shouldn’t be spending 80% of their time on this. Therefore indicators need to be practical—not too labor-intensive. For small organizations that are working with a hidden/invisible/transient target population, it is important to take good baseline data. We also need to choose our funders wisely and communicate with our donors on a regular basis. The UN, for example, is quite strict with changes in log frames, while church groups are more flexible and work on an eye-level with organizations. Accountability should be to the beneficiaries first and foremost. As a suggestion, APRRN could help to share information about donors who understand our challenges.

**Ethnographic interview:**
This approach helps us to develop culturally-relevant indicators for evaluating the effectiveness of psychosocial and mental health interventions. In 20-30 minute interviews, you can assess needs, problems, beliefs, and target groups.

How to use it:
- A brief semi-structured interview, framed around a set of questions, to systematically collect information on a specific topic of interest from a community.
- The responses collected with the interview become “data” which can be summarized through a variety of human or statistical means to identify common underlying themes.

This method can be used for several purposes, such as rapids needs assessment as well as the creation of new assessment or program evaluation measures. Ethnographic interviews are also useful for conducting research. TPO uses it to validate existing measures like the blue cloth method.

Creating the interview: the interview is created around a question or series of questions. It can be as broad or specific as you wish, depending on your purpose. Don’t build in assumptions to the question such as “the person has mental health problems due to domestic violence”. Ask open-ended questions like, “Think of a real person, someone that they know.” (Rather than vague, generalized person.) You don’t have you reflect to yourself. We ask them not to disclose the name of the person they are thinking about. For example: “it would be very helpful to know what problem do victims of domestic violence have, but don’t tell me who it is, a real person who you are thinking about they have to be a victim of domestic violence”.

Designing the interview: once the questions are formed, the interview can be constructed. Start with a statement informing the interviewee something about why we are gathering information. For example: “We would like to understand what problems of victim of domestic violence are...” or “It would be very helpful for us to understand the kind of problems victims of domestic violence have...” If you want to have represented in your sample data both male and females, you will need to repeat the question for each group. For example: if an interviewee, when asked to “think of someone who had problem from domestic violence” spontaneously thought of a
man, then you would want to repeat the question but this time, ask them to think about a woman.

Interviewing logistics: The number of interviews you will want to conduct will depend on the resources available (e.g., staff, time and funding). Plan your sampling method so that sample of interviewees represent the “Community” that you are interested in. It is useful to have between 150 and 250 responses for a sub-population. It’s possible to have smaller sample. The bigger the sample, the more representative it is.

Sampling is a standard technique for quantitative and qualitative methods. If you know more people are affected, the less you have to sample. If you know few people are affected, the more you have to sample. In qualitative design, when the story starts repeating, then you already have the trend (data saturation). When the results are diverse, you should keep getting a bigger sample. TPO often conducts a pilot, analyzes the data of the pilot and then decides whether or not to get a bigger sample.

How to organize and analyze the data:
- Compiling the response data: data are more useful when compiled or grouped into common themes or dimensions
- Narrowing responses: If you framed your interview broadly, or for any reason obtained a number of responses that are not related to your ultimate goal, you may want to narrow responses to those that you believe will be meaningful for your purpose or just remove it based on your expertise.
- Organizing the data: once transcribed, examined, cleaned up, and narrowed, the data are ready to be organized to meaningful groups that reflect common themes or dimensions

Select sort method – 3 methods TPO uses most frequently:
- Single group sort: at least 4-8 people work as a team. To reduce bias through one’s expertise (i.e. gender, livelihoods, etc). This may be the quickest method for grouping the response data and it is a great participatory process.
- Multiple group sorts: This method of sorting is similar as the single group sort; except that two or more groups sort independently. It often takes more time and groups sort at different rates. But it allows you to compare the piles.
- Multiple individual sorts: This method is recommended if the goal is to analyze the results of the sorting process statistically, using principal components analysis, to examine underlying themes or dimensions.

If you have a ton of responses, you can take a random selection of 50 to generate the dimensions and take the rest of the interviews into these generated dimensions.

Baksabat or “broken courage”
Meaning: ‘psychological breakdown of courage’, ‘to be afraid forever’, ‘to never dare to do something again’. PTSD was not found in Cambodian populations because the cultural interpretation of the nightmare is a spirit coming to visit them in the sleep. TPO did a study to create an equivalent to the PTSD checklist. TPO gained an understanding of a local concept of trauma response called ‘baksabat’ and develop a validated instrument more matched to the
Cambodian population. This increased cultural competence for mental health workers in Cambodia.

Ethnographic interviews: 53 experts who can give a clear meaning of baksabat (traditional healers, monks, mediums, health staff, historian, linguistics).
Example: Please tell me about a person you know who has baksabat? If they can’t answer this question, then we ask sub questions.
Quantitative survey: 390 participants: Khmer Rouge survivors and others, who are clients of TPO
Developing the conceptual framework: TPO generated 56 items from the 53 experts, pilot tested this questionnaire with 196 samples. TPO used complex factor analysis to narrow down to 32 most relevant items in the questionnaire. The second factor analysis is validation. The outcome was a culturally-adapted scale with 28 items.

If you want to develop your own culturally-appropriate tool, or have any questions, email Sopheap@tpocambodia.org.

11. Mental Health and Vulnerable Groups
Presented by Meredith Walsh (Burma Border Projects)

Mental health needs and landmine victims
Counselors at the Mae Tao Clinic (MTC) in Mae Sot (Thailand) can help with:
  o Loneliness
  o Anger
  o Sadness, depression, hopelessness, anxiety
  o Insomnia, Nightmares
  o Thoughts of suicide
  o Relationship problems
  o Listening, understanding, and helping to solve problems
Counselling is a conversation between a patient and a counsellor to identify problems and plan for solutions. At MTC individual, family and group counseling, physical therapy, yoga, case management is available. Clients include those who experience: Emotional trauma, alcohol and drug abuse, HIV/AIDS, sexual abuse and rape, domestic violence, unwanted pregnancy, parenting problems, psychosis, children’s problems, anxiety and depression, PTSD.
Landmine client profile:
MTC has around 200 new and replacement prosthetics clients per year. The majority are referred by Karen state and are soldiers or civilians and mostly male. Amputation is available at Mae Tao Clinic of Mae Sot Hospital. Afterwards patients stay at MTC for 6 weeks for post-op recovery, and then return to MTC after 6 months for prosthesis.

Mental health needs for landmine victims:
Injury and amputation affect a person’s body functions/sensation/appearance, activities, thoughts, feelings and connection to others. Social consequences include discrimination, decrease in status, poorer social functioning, isolation, no job, poverty, difficulties in relationships and family problems. Common feelings are sadness, anger, anxiety, fatigue, grief about their loss/injury, hopelessness about the future, low self-esteem, shame about their body, nightmares and powerless because of new dependence.

Common thoughts are: I will never get better, I will never be able to do what I did before, I want to die. Psychological consequences include depression, anxiety, PTSD, body image, sexual functioning and phantom limb pain.

Rehabilitation: Rehabilitation is the process of restoring and improving function, mobility, and independence after illness or injury. It can help us heal physically and emotionally. Rehabilitation can include:
1. Medical and wound care
2. Physical therapy and exercise
3. Counseling and social support

The stages of rehabilitation are surgery and post-surgical treatment, wound healing, recovery, preparing for prosthetic treatment, prosthetics, social re-integration and then follow-up.

Amputee support group: MTC has established an amputee support group for individuals with disabling injuries or amputation (patients and staff) and their family and friends. The group covers education, psychosocial support and physical therapy. The group aims to help the patient to understand the changes s/he is experiencing and adjust to these changes. Furthermore it also aims to regain as much independence as possible, connect the person with people who are or have been in the same situation and work through the grieving process: denial, anger, bargaining, depression, acceptance, hope. It helps with the healing process through healthy coping skills, strong support network, psychological support, understanding, accepting and adjusting to life/environmental changes and resiliency.

Influences on the adjustment process:
**Counseling messages to assist with adjustment process:**

**Phantom limb pain:**
- Sit with a good posture to keep a good blood flow to the amputated limb
- Try to keep the end of your stump warm and protected, and avoid pressure on it
- Keep active & try to imagine you are exercising the amputated limb and see if that helps

**Family/social:**
- Increase contact with supportive family
- Tell and talk with your loved ones about your loss
- Communicate clearly about you what you need and don’t need
- Accept support while remaining independent
- People want to help but often don’t know what to do to support you
- Increase contact with supportive friends
- If your religion or spirituality is important to you, become more involved with it

**Mental health needs for trauma medics:**
Common sources of distress are inadequate skills training, isolation from families and home communities for extended periods, fear of attack from Burmese soldiers, threat of landmine injury, and the experience of forced displacement in early life. Management of stressors can be done through:
- Peer-group interactions and support within medic teams
- Social- and individual-centered coping strategies
- Setting personal and professional goals in relation to their families
- Leadership aspirations

**Support for trauma medics:**
At the Karen Department of Health and Welfare, mental health support trainings are available once per year and are spread over 2-4 days. They include topics such as team-building and communication strategies, group discussion about individual psychosocial and somatic needs, personal stories to feel compassion and create a survivor identity over victimization, explore coping mechanisms and the development of skills for self-care.

One challenge for providing mental health services to landmine victims is that amputees do not always stay at the clinic during recovery. Many amputees ask for help finding a job and are disappointed with “only counseling”. Some patients are also lost during follow-up.

**Ways to improve mental health services for landmine victims:**
- Create a support group for amputees
  - Invite and encourage them to attend the amputee/injury group and other support groups
  - Encourage participation in social activities
  - Introduce them to other amputees at MTC, encourage them to visit each other
  - Explore ways they can enhance their support network
- Advocate for fair treatment of amputees
- Advocate for better services for amputees
- Teach others about amputation and its effects
- Stand up against people who discriminate against amputees
Mental health needs in reproductive health services at Mae Tao Clinic
Presented by Eh Tho (Mae Tao Clinic)

In Mae Tao Clinic’s reproductive health outpatient and inpatient departments, there are 3,000 deliveries each year. The number of deliveries has steadily increased each year since the clinic was established in 1989. Each year the Reproductive Health department sees about 500 cases of women seeking post-abortion care, including those with spontaneous and induced abortion. MTC does not provide abortions, but many women seek care once they experience abortion. Many women use unsafe methods to induce abortion, and they suffer many complications as a result. MTC provides treatment for all women, regardless of their decision to terminate their pregnancies. There are 600 emergency obstetric complications managed at MTC each year. This includes delivery complications as well as complications due to abortion. Family planning services have improved dramatically over the past 20 years, and we now see over 9,000 visits for family planning. 6,000 women seek antenatal care prior to delivering at MTC. However, there are still a significant number of women who delivery without having received any antenatal care.

Services provided in the reproductive health outpatient department are Antenatal care, Family planning, Management of STIs, Post-abortion care, Gynecological care, Counselling.

Contraceptive methods include short-term methods such as oral contraceptive pills, hormonal injections, emergency contraception, and male and female condoms. Long-term methods include hormonal implants (Implanon or Norplant) and non-hormonal copper intrauterine devices (IUDs). The majority of clients use short-term hormonal methods, OCPs and injections, and MTC is currently working to increase utilization of long-term methods to reduce unintended pregnancies and the incidence of unsafe abortion. Women who present with complications of abortion are first seen in the RH outpatient department, and then are admitted to the RH inpatient department depending on the severity of their condition. Many women seek care for gynecological conditions such as cervical, uterine, ovarian, or breast cancer, uterine masses and myomas, ovarian cysts. Many of these conditions require referral to the Thai hospital for surgery. I will talk more about this later. MTC provides an array of counseling services in the RH departments, and I will discuss this in more detail in the following slides.

Services provided in the reproductive health inpatient department are:
• Deliveries
• Emergency obstetric care (e.g. vacuum delivery)
• Post-abortion care
• Complications during pregnancy (e.g. malaria)
• Postnatal care and Neonatal care
• Clinical management of sexual and gender-based violence (SGBV)
• Counselling

MTC sees an average of 7-10 deliveries a day. The majority of EmOC cases are managed at MTC, but 6% of cases are referred to the Thai hospital for C/S. Post-abortion clients are admitted from the RH OPD when complications are present. Women with other medical conditions during pregnancy are admitted in the RH IPD. Malaria is the most common non-pregnancy related reason for admission during pregnancy. Women return after 6 weeks for postnatal care, delivery certificate, and newborn vaccinations. Babies under 6 weeks with complications are admitted.
for neonatal care. Common reasons for admission include jaundice, umbilical cord infection, and respiratory distress or infection. Women who experience sexual and gender-based violence are treated for injuries, provided counseling, and are administered emergency contraception and HIV prophylaxis if they present within the appropriate window of time. All women receive counseling, and overall we have earned that women receive less support for their mental health issues.

First, women have limited power to make decisions in their relationships. This can be with their husband or boyfriend, or any man. For example, women often cannot control whether their husbands will use a condom. And often women cannot make decisions about when to have sex or what kind of family planning to use. Second, women have limited opportunities to learn about family planning. There are few places for women to receive education about family planning. Often the women are busy working and have no time to attend workshops or outreach activities. Some women live very far from the city and they work on farms so they are very isolated. Some women have religious beliefs that prevent them from learning about or using family planning. Third, as a result of limited power and limited knowledge, many women experience unplanned and unwanted pregnancies. MTC sees many cases like this. Women learn they are pregnant when they come to our clinic, and they are very worried. Often they ask us to perform an abortion for them. There are many reasons why women don’t want their pregnancies, whether that is poverty, the need to continue in employment, or the pregnancy resulting from non-consensual sex.

Fourth, as a result of unwanted pregnancies, many women use unsafe methods to induce abortion. There are many ways women try to end their pregnancies. Some go to traditional birth attendants (TBAs) to massage the uterus or to insert the stick, leaf, or medicine in the uterus. Some drink herbal medicine or alcohol. Some drink traditional medicine like Kathy Pan. Fifth, many women have difficulty getting to a clinic for reproductive health services, including family planning and obstetric care. This can be due to the cost and time taken to travel, the inability to leave work, or being unaware that medical attention is required. Lastly, some health workers are judgmental of a woman who has induced an abortion, fostering apprehension about using the service for fear of being reported to the police.

In MTC there are many kinds of counselling services for women’s health, in both the outpatient and inpatient departments. All RH staff is trained to give counselling.

In November 2011, MTC sent 3 participants from the RH department to attend an empowerment counselling training course in Chiang Mai at the International Women’s Partnership for Peace and Justice. In February 2012, these participants helped train over 30 health workers in options counselling for women with unwanted pregnancies. Some of the counselling skills we are now using are deep listening, reflective listening, asking open questions, problem-solving, and screening for eligibility for legal abortion under Thai law. The RH staff is trained to use these skills for women who are struggling with unwanted pregnancies.

We use a checklist to screen women to see if they meet the criteria for a safe, legal abortion under Thai law. There are only a few women who are eligible to be referred to the Thai hospital. However, we believe that we are reducing harm from unsafe abortion by improving our counselling skills and by referring for safe abortion when possible.
Family planning counselling is provided for many clients in the RH departments. MTC offers a comprehensive range, including short-term, long-term, and referrals for permanent methods of contraception. The most common methods chosen are oral contraceptives and hormonal injections. Pregnant clients are counselled on post-partum FP options during ANC and after delivery. Nearly 100% of women accept a FP method before discharge after delivery.

Post-abortion clients are counselled on post-abortion FP options before procedures (for example, before the manual vacuum aspiration) and before discharge. Nearly 100% of women accept a FP method before discharge after delivery. Emergency contraception is most effectively promoted if integrated in all FP counseling sessions, not only when women present within 5 days of unprotected sex. This way women will know it is available if they need it in the future.

In 2011 and 2012, 39 women presented with gynecological conditions which required surgical intervention. Many of these women had been living for many years with conditions such as uterine masses, cervical cancer, ovarian cysts, or breast lumps. Most women noted having sought treatment in Burma, but were either not able to afford the surgery or there were no resources available to diagnose or treat them. Women travelled from remote areas in Burma because they had heard that MTC was a place that would provide treatment free of charge. MTC refers these cases to an organization called the Burma Women’s Medical Fund, which pays for referrals to Thai hospitals. However, before referring these cases, MTC RH staff provides counselling to these women who arrive in distress. Counselling skills are the same as those provided in other situations, with particular attention to the feelings of women who have lost hope after a long period of suffering. RH counsellors screen women to determine their eligibility for referral for surgery.

While MTC does not currently provide screening for SGBV during ANC, it is recognized that this is a very effective way to address underlying women’s health issues. Most women do not present with primary complaints related to SGBV. However, a private space with a counsellor who will listen often provides the space women need to share their problems. When needed, RH staff can refer women to social and legal services such as safe shelters and psychosocial support programs in Mae Sot run by community-based organizations or child protection services in the case of women under the age of 18.

**Important things to remember:**
First, women need private space for counselling so they feel comfortable to talk about sensitive issues. Counsellors can build trust in places where there are no other patients around and where others cannot listen. Second, we understand that many women come to our clinic with a fear that the health workers will judge them. This is common practice in Burmese hospitals. The RH staff knows that they must show compassion in order to provide the best care for women who are experiencing many difficult feelings such as guilt, fear, and shame. Third, women need time to process what is going on. Counselling should be provided not only at discharge. When women are considering a FP method, especially if it is a method they have just learned about, it is best to provide enough time for them to work through their decision-making process.

**Suggestions on how to improve RH mental health services:**
First, as mentioned before, facilities must create a private, comfortable space that is separate from other patients. Second, counsellors must not rush through counseling. If the health worker appears busy and in a hurry, the patient will not feel comfortable to talk about her problems.
Third, the duties of RH staff must be changed so that there is some staff that has enough time to provide counselling with patience. If every staff member is assigned the same duties, there will not be enough time. And lastly, counselling should be offered BEFORE delivery and procedures like manual vacuum aspiration so that women have time to consider what FP method they’d like to choose. For long-term methods like IUD and implants, these are well-suited to be inserted immediately post-abortion or post-partum, so the health worker must know that the woman has chosen these methods ahead of time in order to prepare the proper instruments.

**Mental health needs in HIV services at Mae Tao Clinic**

*Presented by Saw Than Lwin, Health Coordinator, Mae Tao Clinic*

Mae Tao Clinic runs around 1,000 HIV tests/year through VCT and around 4,000 HIV tests/year through ANC. VCT client origins are through internal referrals, migrant outreach organizations or self-referral. HIV services available at MTC include:

- Voluntary counseling and testing (VCT)
- Anti-retroviral therapy
- Treatment of opportunistic infections
- ANC screening
- Prevention of mother-to-child transmission (PMTCT)
- Peer counseling (8)
- Home visitation
- Psychosocial support
- Supplemental nutrition
  - Milk powder to replace breast milk
  - Rice, eggs, sardines, and oil
- Referrals to partner organizations for safe shelter

HIV program clients: Currently there are more than 300 HIV+ individuals supported by MTC. 76 clients are on ART and all of them receive financial support from MTC or MOPH. PMTCT sees around 50 clients per year.

**Mental health needs for PLHAs:**

- Social isolation
- Loss of spouse (divorce/abandonment/death)
- Orphaned children
- Lack of income
- Worry about the future
- Worry about others’ knowing their status
- Harmful behaviors
- Blaming others
- Depression – especially in advanced stage, after ARVs start and situation doesn’t improve

**Mental health needs for caretakers:** Mental health workers are often tired and stressed in taking care of clients who are depressed. There are special needs for HIV+ caretakers, and often clients lack motivation to participate in income generation projects.
HIV counseling services available:

- VCT
- Ongoing peer counseling (facilities-based or home-based)
- Psychosocial support (Self-Help Care group discussion once every 2 months, games, health promotion)
- Support for caretakers at safe shelters
- Peer counseling
  - 8 HIV+ peer counselors (5 men, 3 women)
  - Help patients learn how to be healthy while living with HIV
    - Nutrition and prevention of OIs
    - Ways to prevent transmission
    - Ways to have a healthy sex life
  - Referrals for treatment of OIs
- Psychosocial support (social outings, eating together, games etc.)

Challenges: Majority of the clients have no documentation and can only go by truck, ask for permission from authorities in advance or pay bribes at checkpoints. Some also miss appointments because they do not want employers/neighbors/partners to know why they are always going to the clinic or because employers do not allow them to leave work. Sex workers do not want clients to know, clients in safe shelters have less motivation to work on income generation projects, and domestic violence is also a problem among HIV patients. Sometimes there is also a lack of compliance when the client realizes s/he is dying and severe depression sets in or when the client cannot find a job in Mae Sot and decides to move back to Burma. Additional challenges include the lack of funding to perform CD4 tests for all and patients arriving too late for treatment. Some clients living in Burma can also not receive ART.

Important things to remember: Clients need peers/friends who will listen; ongoing, consistent, and reliable support as well as ART. Caretakers need validation and guidance.

Ways to improve mental health services: To improve mental health services the access to ARVs needs to be increased because feeling physically healthy offers hope. Quality counseling to encourage healthy behavior should be increased as well as psychosocial activities to lift spirits and foster a sense of community.

**Mental health needs for former political prisoners**

Presented by Dr. Htin Zaw (Social Action for Women, Assistance Association for Political Prisoners)

Since 1988 the Burmese government has denied freedom of expression and assembly by stifling opposition through arrest and incarceration of journalists, political activists, ethnic nationalities and human rights defenders. Prisoners experience systematic torture during interrogation and as a result of “violating prison regulations”. They are also denied medical treatment, have poor diet and lack of dental care, and prisons are often located in remote areas far from families. After their release, they cannot work or study, and may be detained again.

**An example of torture:**

In early 2011 Democratic Voice of Burma reporter Sithu Zeya, 21 years, was placed in solitary confinement after failing to understand prison regulations. It was never made clear what
regulations he had breached. For 9 days Sithu Zeya was taken out of his isolation cell every 15 minutes and forced to squat and crawl. It was also believed he was forcibly given drugs, most likely amphetamine, in an attempt to extract more information on DVB’s inside networks. The extreme torture he was subject to during interrogation led him to disclose the identity of his father, Maung Maung Zeya, as a DVB reporter.

As of December 2011, 1,572 political prisoners (PP) were in jail. In 2011-12, 1,015 political prisoners were released and currently over 500 political prisoners remain in jail. The current government denies the existence of political prisoners, claiming all have broken criminal laws.

AAPPB was established in 2000 and is run entirely by former political prisoners. The aims include to advocate for release of all political prisoners and to improve prison conditions in Burma. Activities:

- Provide basic needs to current political prisoners and families
- Document/report human rights abuses against political prisoners and pro-democracy activists
- Secure international support for campaign to release all political prisoners
- Protect political prisoners from harassment and intimidation by the Burmese regime once released from prison
- To assist in the reconstruction of former political prisoners’ lives, including both their mental and physical well-being

AAPPB is widely recognized as a reliable and credible source of information on political prisoner issues in Burma, by the United Nations, governments, Amnesty International, Human Rights Watch and respected media outlets around the world.

Key facts: Former prisoners are twice as likely as others to suffer from psychological difficulties. Almost 1 in 3 of former PP is prescribed anti-depressants. The rate of prescribed anti-depressants for male PP is five times that of age peers. Over half of PP surveyed reported symptoms characteristic of PTSD. Over a third (39.9%) reported suffering clinically significant mental health problems.

Factors that contribute to lack of mental wellbeing among political prisoners include torture, solitary confinement, prison dog cells, denial of family visits, letters, packages, transfer to isolated and remote prisons. Other factors include the use of prisoners in forced labor camps and as porters and minesweepers in areas of ethnic conflict and holding a family member in prison while releasing another.

Mental health concerns:
Political prisoners show symptoms of PTSD with depression and anxiety including crying; abuse of alcohol and drugs; irritability; anger; feeling lonely and hopeless about the future; worrying about thing out of their control; reticence; difficulty concentrating; feeling that there is no one to rely on; no more interest in daily tasks; loss of appetite, and sleeplessness.

Often, political prisoners suffer from anxiety, lack of sleep, and recurring thoughts of terrifying events. Without hope, daily life becomes difficult, and feelings of anger and insecurity can cause withdrawal from others.
Former political prisoners feel that they are misfits to society due to the situations they encounter after their release, fearing re-arrest and harassment from the authorities. One study found that a significant number of both men and women report misusing alcohol (68%) or being alcohol dependent (53%).

Some former political prisoners experience a loss of sexual interest or pleasure, and a common feeling is that others do not understand their experiences and thus cannot comprehend their perspective. Most of the time, community, friends and sometimes relatives are afraid of engaging former political prisoners due to the harassment, social exclusion and pressure by authorities. Friends and acquaintances do not understand what former political prisoners had to go through, and in return, some former political prisoners do not understand the world which they have rejoined.

Rehabilitation is key to readjusting to life in society and having a positive future. Moral support is not enough; many need professional help. Former political prisoners said mental health is a bigger obstacle in their return to normal life than physical ailments, and that the lack of access to mental health care is a serious concern. Group therapy and individual counseling sessions are needed, particularly one-on-one sessions with mental health professionals, who could help evaluate their current mental conditions and organize programs that would include family members. Most prisoners immediately seek a medical check-up once released, but in Burma the regime has pressured health care providers to stop treating former political prisoners. Many doctors in Burma feel pressure not to treat political prisoners. AAPPB assists former political prisoners in securing access to health care. Besides counseling, encouragement and moral support to help regain confidence and readjust to society, political prisoners also need other support tools. This may include support with resuming education, computer and vocational trainings, medical check-ups and follow-up surveys.

Things to remember: Many political prisoners who experience psychological difficulties say they are not getting the help they need. Former political prisoners constitute at ‘at risk’ group for both social exclusion and mental ill health. It is important to create solidarity and a self-sustaining support network for former political prisoners so they never have to feel alone or feel that there’s no one for them to rely on. Overall the way to ease problems is to listen to what former political prisoners say.

Ways to improve mental health services for political prisoners:
• Bring in psychiatric experts and provide medicine to those in need
• Promote mental health advocacy
• Take measures to prevent employment discrimination
• Develop community education for family caregivers of former political prisoners with mental illnesses
• Work to reduce stigma and discrimination against former political prisoners with mental illnesses
12. Working with Children

Presented by Derina Johnson (Burma Border Projects)

Talking about abuse can be upsetting and distressing therefore self-care is important (i.e. taking breaks). Peer support can also help, as a group let others know when it is too much or you need a break.

The following preparations should be made when working with children:

- Know yourself and know your motivation
- Know children and know the child you are dealing with
- Know your environment and the context

Exercise: Know yourself and your motivation – ask yourself the following questions:

- Why do you work with children?
- Which children do you find easy/difficult to work with?
- How could different feelings affect your work?
- Who are you in the child’s eyes? How might that affect their ability to communicate with you?

Girls and women are more comfortable speaking to a woman. Boys and men find it difficult to discuss sensitive subjects with a woman. Especially around gender based violence where the violation was directed against the child due to her/his sex or identity.

Knowing children and knowing this child

A child has had experiences which have lead to certain behavior. We need to understand different components (e.g. abuse, trauma, development, or communication issues) that the child has encountered.

Exercise: To be a child – Draw a picture of your favourite childhood memory and ask yourself what it was like to be a child. Consider the basic needs of a child and what is most important: Food and water, Happiness (attention), Love, Safety

We need to distinguish between differences and challenges such as intellectual/mental disability, learning difficulties and mental/psychosocial health difficulties. Intellectual and mental disability (mental retardation) occurs as a result of brain damage. This can happen during pregnancy (foetal alcohol syndrome), birth (cerebral palsy), and childhood (encephalitis, mumps or other illnesses) or due to genetics (hereditary, congenital, and chromosomal). Genetic causes may account for 5% to 25% of children with development delay. Learning difficulties are not associated with the level of intelligence. Mental/psychosocial health difficulties occur through life experiences such as child abuse, neglect, emotional abuse, childhood trauma and ongoing severe stress.

The presentations of all can be similar. Children with intellectual disabilities have a lack of self-regulation, show anger, don’t know boundaries, and have a difficulty expressing themselves and communicating. Children with learning difficulty are often frustrated, angry and boisterous in class, unable to learn and thus fall behind peers. Children who have experienced trauma or
abuse are withdrawn, untrusting, fearful, and often reject everyone through anger and violence in an effort at self-defense.

**Know the background:**
When working with children it is important to know the underlying causes and if due to a functional difficulty, or a coping difficulty. In addition it is also important to understand the history of the child.

**Stress and trauma:**
Some stress is normal but it is important to normalize stress for children when it is possible. Let them know that you’re confident that they can handle the situation and you are there to help. It is also helpful to explain stress to children through the balloon exercise: Sometimes people are like volcanoes. We can feel our emotion so strongly, it’s like an eruption. When your emotions erupt, you lose control – and that can get you into trouble.

Children need a safe and comfortable environment, proper rest and nutrition as well as attention and affection, in order to cope with stress

**Childhood trauma, childhood abuse, children’s reactions:**
Common reactions in children who have encountered trauma and abuse:
- Very clingy, seeking lots of attention
- Unwilling to leave a place where they feel safe
- Changes in eating and sleeping; wetting and soiling
- Aches and pains in body with no explanation
Knowing the environment, place and context:
Places are emotionally charged for children. It plays a role where you meet children for your work and this can affect how the child behaves or reacts. We also need to understand community beliefs and traditions e.g. how children are treated and cared for and what is considered appropriate/unacceptable behavior.

Activity: Child in community. In groups answer the following questions:
- Words adults use to talk about children; how are adults expected to talk/act with children? Names that they call children?
- How are children expected to talk or act with adults?
- When do children become adults? Legally? Culturally?

Communication with and by children:
Sarah, aged 5, showed the interviewer her dress when asked for her address. The interviewer questioned her ability to communicate. However Sarah knew the answer to the question: Where do you live?

Children communicate through verbal and non-verbal clues and signals, physical/behavioral signs and symptoms. This should be viewed in context of the child and their individual situation as there may be other explanations.

Exercise – How do children communicate?
To explore the ways that children communicate and what is same and different from adults. Think of the times you have noticed children communicating with you or other children. When do they use words? When do they show you? When is it difficult to understand what they mean?

We can help children communicate through eyes, ears and energy. Eyes by keeping eyes on the person we are talking to. Ears by blocking out extra noise and when talking to someone only hear what they are saying. Energy by pulling all our energy into the person we are dealing with, don’t work on anything else or try to do two things at once.

When talking to an abused child be open and remain calm. A common reaction to news as unpleasant and shocking as child abuse is denial. However if you display denial to a child or show shock and disgust at what they are saying, the child may be afraid to continue and will shut down. As hard as it may be, remain as calm and reassuring as you can.

Interviewing a child:
Sometimes you will have to carry out more formalized interviews in cases of abuse in order to fill out necessary paperwork. Remember that the child comes first and the paperwork second. If time is limited, that is not the child’s problem. They need whatever time they need to get through what they need to say.

Interviews should be conducted in quiet, private spaces where the child can feel comfortable and safe. If possible let them choose it. Consider what types of places are good for privacy, safety, no distraction and who else should be present. Children respond well to clarity. If they have been abused, they will be used to secrecy and lying. They will also be more likely to be open with you if you are open with them.
Always explain who you are, who you work for and why you are there. Also explain to the child that you understand this is scary and that you want to ask some questions about when they were hurt. Explain to the child that you are interested in hearing what they think/feel about what happened to them. Even if a parent or carer has indicated consent never try to make/persuade a child to talk. Research has shown that this may influence negatively a young child’s report about sensitive topics (such as abuse) (Ceci & Bruck 1993).

Children usually feel that they are to blame when bad things happen. They need repeated reassurance. Remind them there is no right or wrong answer and that their story is most important. Children usually try to work out what they think an adult wants or expects and will say this, rather than what actually happen. Some children may not have the words to describe their experiences, for instance sex assaults – listen carefully and do not expect specific words or descriptions that an adult may use. Avoid questions asking why. Children don’t know why adults do things and usually feel that they are to blame when bad things happen. If you are taking notes during the interview let the person/child know why you are doing so. If appropriate you may want to read a little of what you have written to make sure you got it right, and/or so they know what you’ve been writing about them.

Be mindful of the attention span of your interviewee, especially as they may also be in a lot of pain. If they get too uncomfortable or upset, stop and take a break and move away from the issue. Take breaks as you or they feel necessary. Make sure there is someone nearby to comfort them if they get too upset.

Flashbacks can happen when a child’s face goes blank, their body seems frozen or the child lashes out when someone accidentally brushed against them. It may occur randomly or when the child is remembering or talking about the event. It happens because a child may be unable to tell you what is happening, but they may be re-experiencing the trauma/abuse. When you notice this gently bring the child back to the present, speak calmly and encourage the child to take a deep breath. Let the child know where she is and remind her who you are. Tell her the day, the time and be gentle. Reassure the child that they are safe. When the child is calm, offer a drink of water or wash her/his face. Pick an object which means safety for the child – a stuffed animal, a squeeze ball, a simple stone the child can hold or keep in the pocket. Help the child to put into words what happened.

End the interview by respecting the child’s confidence and put away the notes carefully. Do not talk about the child with their carers or your colleagues in front of the child. Make sure there is someone who can comfort them afterwards if they are upset.

**Psychosocial support**

Psychosocial programs can look very different and there is no correct and incorrect way. We have to reflect if the aim is to learn (I will show/teach you the correct way) or to express (I want to know more about you). Consider the following fun rules and routines:

- Small number of simple and positive rules/guidelines
- Create a coloring book where children can act out the rules together
- Create a poster of pictures of the positive behavior
- Establish and maintain daily routines (clear daily schedule – regular morning and evening routine)
Praise and encouragement play important roles. The more attention children get for the good things they do, the more they want to repeat the behavior. However, we often give attention and energy to the times when children do things wrong. Start the day with 5 pebbles in your right-hand pocket or 5 elastic bands on your right wrist. Praise a child, move a pebble to your left hand pocket or a band to your left wrist. By the end of the day, you should have 5 pebbles or bands on the left.

Very serious topics can also be taught through games and interaction. Play is the most important thing a child can do. Play is not only fun but it is a great way for them to learn about their bodies, their environment, and the people and objects around them. Play is also the way a child develops self-confidence, learns to express feelings, makes decisions and copes with life. It is the way a child learns how to be a future adult.

Activity: Play – Me and you

What I like about me: I like my__________________, I’m really good at___________, I have a great__________________, I like to___________________, I am proud of______________

What I like about you: etc.

Activity: Play – Drawing

Ask the child to draw what kids are scared of (say that it is ok to be scared of some things). Let the child tear the drawing apart or cross out the scary things or stomp on it. Then ask the child to draw something that makes him/her happy. This exercise gives the child the opportunity to voice his/her fear, remind it of happy things and makes him/her feel better that an adult is present and listening.

Activity – Superhero:

Pretend that you are a superhero who has never been invented before – What do you like? What are your superpowers? How do you use them? Now invent your superhero and draw it in action. How could this be useful for children?

Psychosocial programs – examples:

Classroom based intervention in Burundi and Indonesia, 2002:

This program aimed at children with psychosocial problems, at risk of developing disorders. It combined cognitive-behavioral techniques (psycho-education, safety building, relaxation, exposure-techniques) with creative-expressive therapy techniques such as symptom reduction and strengthening resilience (hope, coping, social support).

In Burundi the program had no benefit. In Indonesia it had an effect of treatment for girls (PTSD symptoms, function impairment and hope) and boys (hope). The reason why the results were different is because the severe damage of civil war and poverty on families, schools and communities. Basic care needs to be addressed first.
Mae Tao Clinic – Child Recreation Centre:

**Care for Carers**

It is a fact that working with children is sometimes difficult. Do this simple exercise:

- Think of your work
- Think of the positives and negatives that come with your work
- How does it divide? Half & half? More one way or the other way?
- Fold a sheet reflecting this division and show it through colors, symbols and textures

There are lots of positives as well as negatives about our job as carers. Sometimes we feel increased irritation or impatience with children, difficulty planning, decreased concentration, intense feelings and intrusive thoughts that don’t lessen over time about the child’s trauma. Some also experience dreams about the child’s trauma and/or denial that traumatic events impact children. The negative impact on ourselves from caring for people can be broken down into two main categories: burnout and secondary traumatic stress. Burnout happens gradually and builds up as a result of ongoing difficulties or feelings of hopelessness in your work. It usually includes feeling worn out, feeling helpless to help children’s situation, beginning to care less about things, feeling impatient and less understanding.

Secondary traumatic stress can happen quickly as a result of a particular event – when you are exposed to others extremely or traumatically stressful events. Upsetting images or thoughts pop into your head. You start to feel anxious about various things all the time can’t concentrate, feel depressed because of the situations, and traumatic experiences of the children.

To deal with compassion fatigue self-care is important. Daily practice of relaxation skills and talking to colleagues, friends and family is also of great importance. Remember to take care of it now to prevent illness or otherwise symptoms might worsen. Self-compassion means being kind, gentle and patient with yourself; to understand you cannot be perfect; to understand that you did not create this situation and to talk to people who love and care you. It is very important to treat yourself how you treat the children.
UN Convention on the Rights of the Child Rights

- Child: under 18 years
- Right to Life: nutrition, shelter, adequate living standard, medical services
- Right to Develop: education, play, leisure, cultural activities, religion
- Right to Protection: protection against all forms of abuse, neglect and exploitation. Special care for refugee children.
- Right to participate: freedom to express opinions about matters affecting their lives

Adult’s responsibilities to children and their development include the following:

- Physical development
  - Physical: food, water, warmth, shelter, clean & appropriate clothing and hygiene
  - Safety: Protection from harm or danger
- Psychological/Emotional development
  - Child feels valued
  - Providing safe, stable and affectionate relationships
  - Showing warmth, praise and encouragement
  - Giving comfort and cuddling
- Social development
  - Providing opportunities to interact with other children
  - Teaching appropriate social behaviors
  - Setting boundaries, effective discipline

Behavioral signs:
Physical abuse: Becoming quiet and withdrawn, talking to only those they trust, Angry, frightened, fearful, bullying others

Behavioral signs: sexual abuse:
- Unusual fear in normal situations e.g. toilet time, changing clothes
- Spontaneously describing sexual experiences
- Inappropriate sexual knowledge – shown verbally or through play with peers, toys or drawings
- Sexualized behavior – squirming, rocking, stimulation with sticks etc.
- Nightmares, bedwetting, reluctance to go to bed
- Sudden changes in mood/altered attitudes to certain adults

Behavioral signs: neglect
- Sad, dejected, passive
- Poor hygiene and health
- Poor body regulations like bloating and gas
- Development delays – intellectual disabilities – poor academic progress

Behavioral signs: emotional abuse
- Poor/unusual interaction with parents and carers
- Unusual reactions/fear in normal situations
- Passive to change in carers/over-affectionate
• Self-stimulation – rocking and head banging
• Stealing, lying, disrupting in school, drop out of school, repeated lateness
• Low self-esteem/confidence, poor self-image, silent and watchful child
• Wetting and soiling
• Loss of vitality/energy, tiredness

**Reactions by age:**

**Children aged 1-4**
Find it difficult to adjust to change and loss; need parents, family and adult carers to help them through difficulties. They may regress to an earlier developmental stage e.g. thumb-sucking, bed wetting, or fear of the dark.

**Children aged 5-11**
Similar to younger children, may also withdraw from peers, compete for attention, and could become more aggressive at school and have trouble concentrating.

**Children aged 12-14**
They will often have vague symptoms of illness, and as above may become disruptive or withdraw. They may begin to experiment with high risk behavior such as substance abuse, and in later adolescence, feel guilt or helplessness.

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**13. Stress management and exercises**

Presented by Ofelia C. Mendoza (Community and Family Services International)

**Stress & Distress**

Stress is a state of psychological and physical arousal that comes about as a result of a threat, challenge or change in one environment (Mitchell and Bray, 1990). Distress is a psychological and physical arousal for which routine stress management is inadequate over time. Attempts to manage it may increase discomfort. Examples of unhealthy, ineffective stress management are alcohol, drug abuse, overwork and putting pressure on self and others. There are 5 aspects of stress response, they include:

1. Physical (body reactions)
2. Emotional (feelings)
3. Cognitive (effort to understand)
4. Spiritual (beliefs and values)
5. Behavioral (actions)

Day to day stress is familiar to us all, and we tend to use an instinctive method of stress management: establishing routine. As daily routine is established, body and mind anticipate the next move, and less energy is expended. Much of the day to day stress is quite positive. It motivates us to get up in the morning, accomplish tasks and seek out new projects and relationships which move us through life.

Cumulative stress is pervasive and subtle, it occurs when a person suffers prolonged, unrelieved exposure to variety of stresses. Causes are usually a combination of personal, work, incident
specific factors which are causing frustration. When not recognized and managed they could sometimes be referred to as burnout.

**Signs of cumulative stress:**

*Physical*: Extended fatigue, frequent physical complaint, Sleep disturbances, Appetite changes

*Cognitive reactions*: Tired of thinking, Obsessive thinking, Difficulty concentrating, increased distractibility/inattention, Problems with decisions and priorities

*Behavioral reactions*: Irritability, Anger, Reluctance to start and finish projects, Absenteeism, Unwillingness/refusal to take leave, Substance abuse and self-medication, Disregard for security, risky behavior

*Emotional reactions*: Anxiety, Feeling alienated from others, Desire to be alone, Negativism/cynicism, Suspiciousness/paranoia, Depression/chronic sadness, Feeling pressured and overwhelmed, Diminished pleasure

*Spiritual reactions*: Doubt of value system/religious beliefs, Questioning of major life areas (profession, employment, life style), Feeling threatened and victimized, Disillusionment, Self-preoccupation

**Signs of burnout in organizations:**
- High employee turnover, Increased sick leave, Clique formation, Scape-goating, Frequent conflicts, Lack of initiative, Lowered work output

**Signs of burnout in individuals:**

*Physical*:
- Loss of energy, Frequent and prolonged colds, Headaches, Sleep problems like insomnia, nightmares, excessive sleeping, interrupted sleep, early awakening, Ulcers, gastrointestinal disorders, Weight loss or gain, Flare-up of preexisting medical disorder, Injuries from high risk behavior, Muscular pain: neck and lower back, Increased premenstrual syndrome among women

*Emotional*:
- Depression, Helplessness, Feeling trapped, Irritability and anger, Frustration, Over reactions and under reactions

*Attitudinal*:
- Disillusionment, Low morale, Focus on failures, Loss of emotional meaning of work, Distrust, Cynicism

*Behavioral*:
- Absenteeism, Increased consumption of caffeine, tobacco, alcohol and drugs, Tardiness, Difficulty expressing oneself verbally and in writing, Accident prone, Poor performance and reduced effectiveness, Disrespect, Over-activity/under-activity, Unwillingness to take leave, Risk taking

The following stressors can cause burnout:
- Lack of resources in people and time to get the job done
- No control over the situation
- Inability to make the organization perform according to expectations
- Unwanted organizational changes
• Organizational politics
• Lack of support from top management
• Top management interferences
• Unmotivated workers
• Unrealistic expectations
• Lack of recognition

The 5 components of stress management are:
Exercise, Nutrition, Rest and sleep, Relaxation, Communication to manage stress

Exercise is an activity which moves the whole body through space for a period of twenty minutes or more with some rise of respiration and heart rate counts as exercise. Physical and mental fitness go together and the qualities of strength, flexibility and reliability in one’s physical being translate to mental attitudes as well. Most of us can, if we are determined, find twenty minutes for physical activity most days of the week.

Nutrition – We best meet our bodies needs with regular easy to digest meals including fruits and vegetables as well as plenty of fluids and snacks such as nuts and cereals. We limit nutritional stress by avoiding excess of sugar, caffeine (in coffee, tea, cola drinks) and alcohol (high in calories, low in nutrients, interferes with absorption of stress fighting vitamins and acts as a depressant).

Rest and sleep – Exercise is key for many people to improve sleep patterns affected by stress. Another key is being aware of how much sleep you really need on an average to feel your best. You can then watch in your sleep bank account, replenishing it with an early night when you are overdrawing. In stressful periods the need for rest may increase, along with fatigue levels. As fatigue itself is a major source of stress, it is wise to address it by building in timed rest and sleep sooner rather than later.

Relaxation strategies are as varied as the personalities of those using them. Most relaxing activities, however, have the following characteristics:
• They provide an area of complete control, from the choice of the activity to the time of beginning and ending it, and the frequency of enjoying it.
• They may provide the person with needed time alone. In this category, a bath, if available, is first choice for many people. Listening to music through the gadgets and reading are also popular escapes.
• They may be comforting reminders of childhood, connecting you to the person who taught you memorable and useful things.

Sometimes activities are chosen for their quality of providing structured interaction with others (e.g. games with other people or computer games). Some find cooking special food for friends as relaxing, while others will find relaxation from being with nature.

Communication about stress – We have varied instincts about how and when to communicate about stressful situations and critical incidents. Communicating difficult experiences is an important avenue to integrating it and moving on. A communication repertoire may be especially important when working in isolated, harsh or uncongenial circumstances. Such a
repertoire may include a journal, letters, use of stress buddy system, monitoring self-talk and inner dialogue, participating in informal stress defusing or support groups, group or personal stress debriefing, communication with higher powers through meditation or prayers and expressive hobbies (art, photography, blogging).

**Exercises:**

*The Sigh*

Yawning or sighing is a sign that more oxygen is needed by the body. We often sigh when things are not quite right, as a way of releasing tension. Purposeful sighing can be used to refresh and relax. The group noisy sigh is relaxing because of the laughter which inevitably follows it.

**The Relaxing Sigh:**

- Stand or sit straight. Breathe in deeply, and then let the air rush out of your lungs.

**The Noisy Sigh:**

- Stand and or sit straight. Breathe in deeply, and then let the air rush out of your lungs. Repeat, but this time let out a deep relief with the air

*Deep breathing*

Deep breathing is a skills requiring practice. However, even a short session can refresh and relax as oxygen comes into the body.

- Sit comfortably with the feet on the floor
- Put your hands on your lower abdomen. Inhale slowly and deeply through your nose and into your abdomen, so it expands to push up your hands as much as it feels uncomfortable. Your chest should move a little.
- Exhale through mouth, letting the air leave with a slight sound like the wind
- Repeat with a rhythm that feels comfortable, with each breath pushing your hands
- Your shoulder, mouth, tongue and jaws should be relaxed as you breathe in and out, relaxing

*Stretch break*

- Stand up; Stretch both arms above your head. Stretch to one side then the other, hands joined over head. Bend over from waist, relax arms and legs. Continue stretching as desired

*Take weight off your shoulders*

- Breath in through your mouth
- Raise shoulders towards ears
- Breathe out through mouth
- Drop shoulders and repeat
- Rotate shoulders backward five times and forward five times
- Rotate neck slowly five times in each direction

*Nine joints*

Neck: slow rotation of head in a circle, to the right then to the left (8 counts each)
Shoulder: rotation of the shoulders, backwards then forward (8 counts each)
Elbow: rotation of the elbows (30 seconds)
Wrist: rotation of the wrist to the right then left (8 counts). Spread out fingers one by one.
Waist: rotation and shaking of the hands (30 seconds)
Hips: clockwise (8 counts) and counter clockwise (8 counts)
Knee: rotation of the knees, inwards (8 counts) and outwards (8 counts), left (inwards/outwards), 8 counts each.
Ankles: rotation of ankles to the right and then to the left (8 counts)
Spine: U position- bend forward as far as it is comfortable, and then do the inverted U.

14. Interviewing, listening skills and referral
Presented by Ofelia C. Mendoza (Community and Family Services International)

Characteristics of a good helper/service provider include:
- Knowledge of the legal and psychological framework of the project
- Knowledge of the legal and psychological environment of the place/country, where the project is being implemented
- Knowledge of and sensitivity to the cultural background of the population being served
- Sensitivity to vulnerability issues of the population being served
- Academic background/professional expertise in the area of work

Interviews:
An interview is a face to face meeting between two or more persons. The interviewer directs the interviewee/s towards a purpose.

Skills required for effective interview include:
1. Skills in asking question: ask question in friendly manner, know the various types of questions, tone of voice
2. Focusing, guiding and interpreting:
   a. paraphrasing and summarizing often clarifies what has been said
   b. Confrontation brings about into open feelings, issues and disagreements
3. Skills in relating with interviewee (rapport building)
   a. Accepting people as they are
   b. Individualizing people
   c. Observe and assure interviewee of confidential nature of the interview
   d. Protecting the confidential nature of the interview
   e. Allowing the interviewee to participate and become self-sufficient
   f. Exercise self-discipline (avoid using pressure, imposing advice and other forms of power on interviewee)
   g. Demonstrate caring attitude toward interviewee
4. Observation skills
   a. Sensitive to non-verbal, behavioral ways
   b. Observe the following: body language, content of opening and closing statement, shifts in conversation, association of ideas, recurrent references, inconsistencies and gaps, dynamics between family members/individual group members
5. Skills in listening
   a. Listening before talking
b. Picking up important points for elaboration

c. Giving brief, relevant comments or questions that show the interviewee’s account to express his feelings

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Desirable non-verbal communication:

1. Facial expression:
   a. Direct eye contact
   b. Warmth and concern reflected in facial expression
   c. Eye on same level with interviewee
   d. Appropriately varied and animated facial expression
   e. Mouth relaxed, occasional smile

2. Posture
   a. Arms and hands are moderately expressive, appropriate gestures
   b. Body leaning slightly forward, attentive but relaxed
   c. Open posture

Guidelines that contribute to an effective interview:

1. Prepare for the interview
   a. Comfortable interviewing room, where confidentiality is safeguarded
   b. Prepare yourself
   c. Anticipate possible problem/s or situation that interviewee will present

2. Start the interview by mentioning your role or position in the agency and explaining the purpose of the interview
   a. Enables the interviewee to feel comfortable and to talk freely through your verbal and non-verbal messages that convey understanding, acceptance of his/her feelings and views
   b. Crucial is the show of respect to the interviewee

3. Begin the information gathering on the interviewee’s cue
   a. Ask question that clarify what the interviewee is saying
   b. Monitor communication and maintain a sense of timing attuned to the interviewee’s pace
   c. Don’t allow note taking to interfere with the interview
   d. Pay attention to the interviewee’s verbal and non-verbal messages

4. End the interview with a short conversation that provides a transition out of the interview
a. Summarize what has happened and invite the interviewee to ask questions 
   b. Plan the next step with the interviewee 
   c. The interviewee should be at ease when the interview ends (scaling question) 

**Post Interview:**

- Preparation of report: 
  - Evaluation/assessment 
  - Recommendation 
  - Plan for monitoring of agreed upon action points 
- Coordination with other service providers that can provide needed resources by the family 
- Conferencing with colleagues, case manager, co-therapist 
- Referral if outside services are needed 

**Referral:**
Referral means linking clients with formal organizations and informal support networks. It involves making good connections and other necessary action to ensure that the client actually receives the needed assistance. Referral also involves clarifying client needs, connecting them with relevant services and preparing the client. Then select appropriate agencies with relevant services. An index of working resources includes availability, adequacy, appropriateness, acceptability and accessibility of services. The existence of a network will facilitate easy access of client to needed services.

**Characteristics of informal networks include the following:**
Size: The number of members within the network will affect each member’s role in the helping process 
Helpfulness: The interest and willingness of network members to help will be valuable in developing supportive ties 
Intensity: The frequency of contact between the members will affect the extent and quality of available support 
Durability: Refers to the length of time of the network’s existence. A long-term connection between the client and the network member can indicate a more sustained level of social support. 
Accessibility and proximity: The network members’ physical location and openness and availability in terms of time and energy will affect the success of linkage. 
Reciprocity: Refers to the flow of support between the client and the members of the network
15. Suicide assessment
Presented by Judith Strasser of Transcultural Psychosocial Organization Cambodia

Suicide is an issue among refugee populations in several settings:
- Legal aid providers are often encountered with it during interviews
- Refugees often feel abandoned and not part of the society
- Long waiting time for refugee status
- Common in detention
- Cultural aspects: For example Sri Lankans tend to see it as an option

Suicide rates are higher in urban areas than rural areas. Suicide risk factors include past suicide attempts, family history of suicide, mental health (depression, PTSD, etc.), situational risks (job or financial loss). Refugees have additional risks because of the exposure to violence, loss of traditional support, stigmatization, unrealistic expectations, feelings of abandonment and financial problems. If families migrate, the younger generations more easily pick up assimilation.

Suicidal people keep their plans to themselves and it is therefore difficult to confront a person about suicide.

Clues and warning signs

Behavioural signs:
- increased substance abuse (especially alcohol)
- domestic violence
- giving away important things
- taking unnecessary risks
- putting personal affairs in order
- depressed and feeling hopeless
- sudden irritability or mood changes
- sudden interest or disinterest in religion
- obtaining the means to commit suicide

Direct verbal clues: “I wish I were dead”, “If [such and such] doesn’t happen, I will kill myself”

Indirect verbal clues:
- My family would be better off without me
- Increased stubbornness

Interventions in general should focus on reconnecting the person with his/her direct environment and empowering the person with coping resources. The mental health worker can help to identify positive things in his/her life at the present time, which can also be difficult. He/she can also help to develop awareness about how mental message reinforce his/her messages and help to develop awareness of factors that trigger suicidal ideation. The expression of emotions and feelings should also be encouraged. Another option is to get an agreement or signed contract that the client does not commit suicide in the time the mental health worker doesn’t see the client. Family members or significant others can also be informed and asked for a 24 hour suicide watch.
Coping strategies:

- Keep communication open and ongoing with family, community members and counsellors
- Express negative emotions and accept feelings without judgment
- Don’t make major decision during crisis
- Create goals (no matter how small) and acknowledge daily progress
- Make a commitment to self-care: eat well, sleep enough, physical exercise
- Trust in the larger universe can help (depending on the cultural background)

Toolkit: QPR (Question > persuade > refer)

Question: Sometimes asking the question can be difficult some clients are also pretty direct on the other hand. You can ask direct questions how they are planning to commit suicide?

Persuade: Being physically and mentally present is already a form of intervention as it required a lot of attention and presence from the counsellor or lawyer. The helper needs to acknowledge difficulties, let the person know that you are and take him/her seriously, and keep in mind that suicide in not the problem but an attempt to solve the problem. Try to dissuade the person from using drugs or alcohol and try to finds peer support for him/her.

Refer: Link the client to resources such as an anonymous call-in-center. Try to identify resources in the immediate neighborhood of the person. Assess if the person needs 24 hour observation or care. In most countries however it is a problem and there are no 24 hour institutions available.

Follow-up: continuous support is needed and it is important to follow up with the person after admittance to an institution or hospital. Centers are usually more suited to deal with a crisis than a psychiatric hospital. Suicide is not a psychiatric disorder but a state of crisis.
16. Action Planning

The action planning session was structured in 2 parts: a mapping exercise to identify existing services, challenges and strategies, as well as brainstorming on action plans for 2012 and 2013.

Existing services:
Thailand:
- Thai-Burma border: several NGOs provide mental health services inside the camp, they include: Aide Medicale International, Salus World – Fortune, Karen Department for Health and Development, ZOA Refugee Care, World Education Thailand, Social Action for Women, Burma Border Projects, International Rescue Committee, American Refugee Committee and Mae Tao Clinic.
- Urban refugees in Bangkok: Jesuit Refugee Services, Bangkok Refugee Centre, IOM (but unclear what exactly they are providing)

Burma:
- Salus World (urban based and some work done after Cyclone Nargis)

Philippines:
- Community Family Services International

Cambodia:
- Transcultural Psychosocial Organization (not working on refugee issues)

Indonesia:
- International Catholic Migration Commissions (ICMC)
- JRS Indonesia

Malaysia:
- Health Equity Initiatives
- Malaysian Social Research Institute


Challenges across the region:
- Lack of organizations working on mental health and limited services available
- Lack of interpreters and quality of existing interpreters
- Lack of coordination between different service providers
- Access to vulnerable groups since they are often in hiding (domestic works, on boats, plantation or in detention)
- Limited assessment on mental health issues and the scope of the problem among refugees
- Mental health is not a priority and there is a lack of knowledge and awareness
- Harsh legal environment, lack of legal status, long RSD process for urban refugees
- Stigma among the refugee community itself
- No focus on advocacy, only service provision

Strategies to address challenges:
- Dialogue and collaboration to strengthen coordination
- Adapting models/best practices from other countries
- Resources: staffing and long-term funding is needed
- Capacity building and training
- Develop strategies to work with limited resources

**Brainstorming on action plans:**
APRRN has separated the actions into three different areas: Network development and collaboration; capacity building and advocacy.

1. Network development and collaboration:
   a. Sharing of already developed resource manuals and information
   b. Establishment of a mailing list
   c. Development of a toolkit on refugee mental health (groups could connect with AAT, which has already developed a toolkit on legal aid)
   d. Development of directory and mapping of mental health providers in the region
   e. Sharing of information between Thai-Burma border organizations and organizations working in Bangkok
   f. Look into a more formal refugee mental health group/network for the Southeast Asia region

2. Capacity building:
   a. Organizing another training workshop and regional conference on refugee mental health in 2013
   b. Interpreter training (maybe this could be linked with interpreter training for legal aid)
   c. National trainings on refugee mental health
   d. Training for immigration detention officials
   e. Identify and develop pool of long-term volunteers
   f. Mentoring programme

3. Advocacy: Research for evidence-based advocacy
## 17. Feedback and evaluation

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<th>DAY 1</th>
<th>Very good</th>
<th>Good</th>
<th>Neutral</th>
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The majority of the participants found the trainers very competent and liked their training methods. It was suggested to use more experiential methods for some topics and have more time for the various sessions. Participants found that the group was too diverse and that it should be grouped into different levels. On the other hand the diversity of participants was also appreciated because it generated dynamic discussions and exchange of ideas/experiences.

Topics can also go more into depth next time and should focus on more practical skills. It was appreciated that the training also provided the opportunity for refugees to attend.

Over 80% found the training useful for their own work and will be able to apply in their own context and work setting. Majority of the participants also think there is a need for a follow-up training

“The trainers were very capable in their areas and approached their training with enthusiasm”.  
“Excellent – one of the best trainings I attended”  
“It enabled me to reflect on my own programs and how to improve them.”  
“This training is useful for my own organization – I could learn from other organizations and improve my own work.”