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PROJECT REPORT
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STUDENTS AND TEACHERS AT UNIVERSITY OF BERGEN,
TRIBHUVAN UNIVERSITY, INLAND UNIVERSITY COLLEGE, AND
VIETNAM NATIONAL UNIVERSITY

CENTRE FOR CRISIS PSYCHOLOGY PSY380B

UNIVERSITETET I BERGEN

PREFACE

This report is a product of the international semester at Centre for Crisis Psychology 2021. The participants were psychology students from Norway, Viet Nam, and Nepal. The students in Norway were in the middle of their studies, while the other students had already graduated as psychologists and were either PhD students or advanced students.

The semester was divided into three modules. The first course was Introduction to Global Mental Health. The second course was Crisis Psychology and Disaster Response. The third course was a 5-week project period where the students were to apply some of their recent obtained knowledge. This report is a product of this project period.

The course Introduction to Global Mental Health introduced the students to mental health and mental health services as an integral part of health in a global perspective. In this course, the students were to gain knowledge about mental health and mental disorders across contexts, and about the existing gap between needs and services. The objective of the course is to provide the students with knowledge and skills that can be used to promote mental health and resilience, in order to prevent and treat mental disorders. The aim of the Crisis Psychology and Disaster Response course was to introduce the students to the research and practicum area of crisis psychology and clinically anchored assessment in a global context, as well as interventions and counselling to families, health professionals, and community-based services. In the final 5-week module the students applied and expanded their knowledge from the two first courses of the semester. Students worked on applied projects related to global mental health and crises. Travel, observations, and field work were parts of this course to the extent possible during the COVID-19 pandemic.

The semester was organized and supported by many people and institutions, including the capacity building programme NORPART. The main responsible staff were Unni Heltne and Ragnhild Dybdahl from Centre for Crisis Psychology. Other staff at University of Bergen, including Centre director Jarle Eid, Gøril Vikøren Nøkleby and Hanna Tandberg played vitals roles and worked hard from the planning phases until the final course. Professor Suraj Thapa from University of Oslo and professor Mita Rana from Tribhuvan University were central to the include Nepalese students. Associate professor Kerstin Söderström from Inland University College in Norway as well as professor Dang Hoang-Minh from Vietnam National University made the Vietnamese participation possible. Several guest lecturers contributed through the semester. Many more people should be mentioned and thanked. Please know how grateful we are for your contributions. The students were active and engaged learners and contributors, sharing their experiences. They were adjusting to the changing contexts of the pandemic, collaborating across time zones, languages, cultures, and competing duties.

We thank all who have been part of this semester. It has been an academic and personal journey for all of us. We hope the report will be valuable for those who took part and remind us all of friendships and learning, as well as useful to others who wish to learn from our international semester.

Gracjana Plociennik Unni Marie Gulla Heltne Ragnhild Dybdahl

PART 1

CHAPTER 1

INTRODUCTION

Some of the Topics covered in global mental health and humanitarian emergencies

Ragnhild Dybdahl & Unni Heltne

Health is a human right. Health is more than absence of illness. Health is also the presence of wellbeing. Wellbeing and health consist of biological, social, mental, and existential aspects. In reality these aspects are interlinked. Thus, mental health is an integral part of health. Mental health is also not only the absence of mental illness, but presence of wellbeing, the possibility for people to develop and release their potential, the ability to be part of, and contribute to, community, and the ability to handle normal challenges in life. Therefore, mental health is essential for developing societies' resilience, for fighting poverty, climate change and inequality. These definitions stem from the World Health Organization and are part of the basis for the international semester at Centre for Crisis Psychology where staff and students work together to learn and develop skills and knowledge so that psychologists can contribute in the global efforts to reach the sustainable development goals and handle global challenge. The main topics for this semester are global mental health, crisis psychology, and global cooperation.

Professor Vikram Patel states that when it comes to mental health, all countries are developing countries. Professor Patel also says that we cannot go on as we have done till now. More involvement of people with lived experience is needed. Innovative approaches where there is task sharing and where services are available where people live, and that are culturally acceptable, are needed. In addition to reaching a much larger proportion of people by involving and training non-specialist professionals, task-shifting may further facilitate communities to care for and support others in ways that encourage recovery and strengthens collective structures that are important for daily functioning and wellbeing (Inter-Agency Standing Committee, 2019).

In the course Introduction to global mental health, several topics were taught. These included stigma and human rights, vulnerability, resilience, empowerment and lived experience, culture and context, health diplomacy, collaboration across sectors and disciples, human development, life course approach, early childhood development, and complex emergencies and humanitarian contexts. Student projects built on these topics.

Context
Take context as starting point. What resources and needs exist? What are local perceptions, practices, values, concepts, and beliefs? How can and should various interventions and approaches be developed, adapted, or changed?

Stigma and human rights
The challenges are particularly grave for marginalized people. In every country there are groups of people who are particularly vulnerable and subject to discrimination. Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

Evidence-based practice.
Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

The mental health action plan
The 66th World Health Assembly, consisting of Ministers of Health of 194 Member States, adopted the WHO's Comprehensive Mental Health Action Plan 2013-2020 in May 2013. The mental health actions plan by the WHO relies on six cross-cutting principles and approaches:
1. Universal health coverage: Regardless of age, sex, socioeconomic status, race, ethnicity, or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

Multisectoral approach
A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

Lived experience of persons with mental disorders and psychosocial disabilities
Lived experience is crucial for human rights, for combatting stigma, and for effective and relevant interventions. Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research, and evaluation.

Life course approach
Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood, and older age. It is widely accepted that the development of the youngest children is critical for the development of individuals and societies.

Despite the strong evidence of the importance of healthy ECD, progress is scarce for many children as there is a lack of access to early childhood interventions, especially for children that are disadvantaged. To conceptualise the promotion of early childhood development, the *Nurturing Care Framework* was launched in 2018. Nutritional, health, education, and protection are important entry points for providing evidence based holistic support that take all areas of children's needs and rights into consideration. in the first place, as they live in adverse contexts with cumulative challenges. Enabling young children to achieve their full developmental potential is a human right and an essential

requisite for sustainable development. Given the critical importance of enabling children to make the best start in life, the health sector, among other sectors, has an important role and responsibility to support nurturing care for early childhood development. New WHO guidelines (2020) provide direction for strengthening policies and programmes to better address early childhood development.

Humanitarian conditions
(https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies)

Conflicts, disasters, and crises pose particular risk for mental health. More people suffer from mental health conditions during and after humanitarian emergencies than was previously thought (Charleston et al, 2019).

There are various types of social and mental health problems in any large emergency. These could be social problems, including as pre-existing (e.g. poverty and discrimination of marginalized groups), emergency-induced (e.g. family separation, lack of safety, loss of livelihoods, disrupted social networks, and low trust and resources); and humanitarian response-induced (e.g. overcrowding, lack of privacy, and undermining of community or traditional support).These could also be Mental health problems, including pre-existing (e.g. mental disorders such as depression, schizophrenia or harmful use of alcohol); emergency-induced (e.g. grief, acute stress reactions, harmful use of alcohol and drugs, and depression and anxiety, including post-traumatic stress disorder); and humanitarian response-induced: e.g. anxiety due to a lack of information about food distribution or about how to obtain basic services).

International guidelines recommend services at several levels–from basic services to clinical care–and indicate that mental health care needs to be made available immediately for specific, urgent mental health problems as part of the health response.

Community self-help and social support is important and need to be strengthened.

Psychological first aid offers first-line emotional and practical support to people experiencing acute distress due to a recent event and should be made available by field workers, including health staff, teachers, or trained volunteers. Clinical care for mental health should be provided by or under the supervision of mental health specialists such as psychiatric nurses, psychologists, or psychiatrists. **Links and referral mechanisms** need to be established between mental health specialists, general health-care providers, community-based support, and other services (e.g., schools, social services, and emergency relief services such as those providing food, water, and housing/shelter).

WHO and others work to ensure that the humanitarian mental health response is both coordinated and effective, and that following humanitarian emergencies, all efforts are made to build/rebuild mental health services for the long-term.

CHAPTER 2

Mental health and mental health conditions

By Nguyen Thanh Tam & Lea Grøstad

What is mental health and mental illnesses?
Mental health is a component to health that is both integral and essential. According to WHO, mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Otherwise, mental health in the APA dictionary of Psychology refers to a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.

A lot of different things affect our mental health. We can see how biological, psychological, and social factors work together and influence our mental health. We can find both risk and protective factors in all these fields of focus. Social support is something we know is important for mental wellbeing, and specific personality traits and psychological factors can also make people more vulnerable to issues. We are aware that rapid societal change, demanding work environments, sex discrimination, social inequality, unhealthy habits, poor physical health, and violations of human rights are all linked to poor mental health, as well.

However, many people hesitate to talk about their mental health problems because of the stigma in their culture. Unlike physical health issues, like cancer or heart disease, mental illness is by many considered one's weakness. But any health problems that cause substantial changes in thought, emotion, and/or behavior, and difficulties interacting at social, work, or with family are referred to collectively as mental illness. No matter who you are, your age, gender, religion, geography, race or background, mental disorder can impact anybody.

Mental illnesses come in a variety of shapes and sizes, and some of them are curable. Scientists are constantly learning more about how the human brain works, and there are medicines and treatments available to help patients effectively manage mental illnesses. Some disorders are moderate and have only restricted impact on everyday life while other mental health issues are so serious that they may necessitate hospitalization.

In this chapter we will focus on mental health and mental health conditions in the contexts of Nepal and Viet Nam. The information will be based on observations from working in these areas. From Nepal we will focus on the facilities at a hospital and then how religion and culture affect the understanding of mental health. From Viet Nam, the development of psychology and psychiatry, experience in a mental hospital and religion influences will be discussed.

Why is mental health important to focus on?
When talking about mental health, it seems logical to start by reflecting on why a mental health focus is so important. There are many different reasons for this importance. Of course, it is important for the individuals struggling with mental health issues to get the help they need and deserve. Being able to live good and healthy lives may be a goal in itself, but there are also other reasons.

Good mental health can be seen as important for the development of a country. With good mental health it is more likely that people will contribute to society. 600 million people suffer from depression and anxiety worldwide, and mental health conditions cause 10 to 20 years lower life-expectancy and 1 in 5 years lived in disability. This means many years where the individual normally would be able to work and contribute. Also, it is noted that one in every five persons is likely to have a mental health condition at some point in their lives. This demonstrates the prevalence of mental health issues.

It also affects other people than just the individual struggling. If a child is having mental health problems leading to them not being able to go to school, one parent probably must stay at home with the child. This will lead to the parent not getting paid, or maybe lose their job. This will further affect the society where the person will not be able to contribute. A mental health problem can affect everyone.

Mental illness can make you unhappy and interfere with daily life, such as in education, workplace, or in your relationships. Education is an important focus point in the sustainable development goals, and we know that it is important for the development of a country. If a child struggles with mental health issues, attending school will not be easy, and the child will not be able to focus and learn. Depression and other mental diseases are linked to greater rates of impairment and unemployment, as well. Approximately 20% of the time, depression impairs a person's ability to do physical job responsibilities, and about 35% of the time, depression impairs cognitive performance. This is also a reason why focusing on mental health is important.

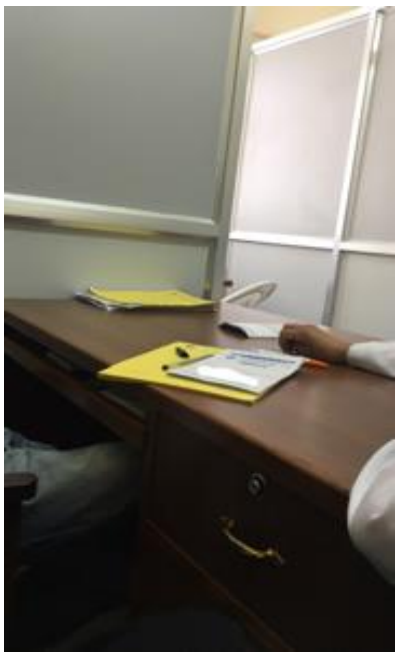
By focusing on mental health, it could be possible to get more money invested, and a better understanding of how mental health is just as important as physical health. We could get a better understanding on how mental health influences different aspects of life, and how it is important for the development of a country and to reach the sustainable development goals. It is profitable to invest in mental health. One dollar invested in mental health leads to four dollars in return in better health and ability to work.

Mental health in Nepal - Observations from TU Teaching Hospital

We have shown that working with mental health is important for many different reasons. Now it is time to look more into the two contexts that shall be discussed in this chapter. First, a presentation of the context where the observations are done, starting with Nepal.

At Tribhuvan University Teaching Hospital (TUTH) in Kathmandu there are several facilities for meeting the needs of people with mental health problems. There is an outpatient department (OPD) and different wards, including psychiatric and addiction wards. In Nepal only three new clinical psychologists are educated each year. At present time there are 37 clinical psychologists in Nepal, which is populated by nearly 30 million people. These numbers clearly tell us there is a need for more resources and focus on mental health.

University Teaching Hospital Tribhuvan



At the OPD and the different wards, we saw the need for more resources, both in the form of people and money. At the OPD there is always people waiting in line, and there is no room for breaks between the patients for the staff. They try to meet the needs by making the students in clinical psychology and psychiatry talk to the new patients and discuss the case with a psychiatrist or psychologist before setting the diagnosis and choosing what treatment to give. This is a good way to use the personnel available, but there is a risk that people are not met in the way that they should since the students don't necessarily have all the knowledge and skills needed to meet people in vulnerable situations.

The picture is from the OPD. You can see the chair in the other room, showing how close the patients are sitting. There are no patients in this picture

There are a lot of different cases at the OPD, but some of the most common cases are mood disorders, anxiety disorders and dissociative disorders. The most severe cases from the OPD can get transferred to the psychiatric ward. At the psychiatric ward, there is one room for women and one for men. Each room has six beds. At the addiction ward most of the cases are alcohol and cannabis related addictions.

When we look at treatments at offer, we saw that medication is widely used - mainly antidepressants and antipsychotic drugs. It is usual that the patient gets a diagnosis and medication in their first session at the OPD. There are different reasons why medication is so widely used. It might be that it is easier to look at mental illness as something biological, and that this might reduce stigma. It is not about something happening in your mind that you need to talk about, but just something happening in your body that you cannot control but can treat with medication. Medication might also be an alternative to other treatments that are not available to everyone due to lack of resources. Some also say that people expect to get medication, especially when they travel a long distance to get to the hospital. If they do not get the medication, they may not come back. So, for other treatment offers to be followed up, medication is also needed to keep the patient.

Other treatment offers are different ways of counselling. There may be focus on ways to deal with stress, like grounding- and breathing-exercises. Cognitive behavioral therapy is also widely used and other forms for psychotherapy. Psychoeducation for both the patient and the family is seen as important. There is also a focus on family therapy.

When we look at the problems people talk about in the OPD, we find that a lot of stressors are connected to family. There seems to be a large focus on the situation and the family around the patient. This could reflect the collectivistic culture of Nepal. Almost every patient has an informant coming with them, and this is usually members of the family. When discussing cases, there is also a large focus on the family, and every individual in the family gets mentioned. It is natural that worries related to family are important to an individual.

We experienced that there now is a more focus on mental health in Nepal, and that there exist some offers for people struggling. In the next part we will discuss further the context and culture of Nepal.

Mental health in Viet Nam - The development of psychology and psychiatry in Viet Nam and observations from Bach Mai Hospital

Mental diseases have received little attention in Vietnam. Although the frequency varies by year, the ten most frequent mental illnesses are as follows: Dementia; Schizophrenia; Epilepsy; Traumatic brain injury; Mental retardation; Depression; Anxiety; Behavioral disorders in adolescents; Alcohol abuse and alcoholism; Mental disorders due to drugs.

The interest in mental health has paralleled the development of psychiatry and psychology. Despite the fact that the network of mental health institutions is not yet complete, efforts are being made to increase parity of access to mental health services.

The first mental hospital - which was called “mad house” - was established in 1919 in Bien Hoa province. Later, in 1936, another hospital with 400 beds was founded just for people with mental illness in Bac Giang province. In 1976, the Vietnamese government officially enacted Resolution 15 to construct a mental hospital system throughout the country. This is a key moment in the development of Viet Nam's psychiatry sector and the improvement of mental health care services. The authority has given each province and city the authority to build a mental hospital with 100 to 500 beds. Because two diseases (epilepsy and schizophrenia) are classified as "societal diseases," sufferers have received free treatment and all their medications from the government. Since then, a number of provincial psychiatric hospitals have been created and placed into service, resulting in a clear and effective growth of the mental health sector in the health care service for the Vietnamese people and community.

Vietnamese psychology; otherwise, started its first steps after the 1950s by students studying abroad and majoring in psychology and education in the Soviet Union. At the time, psychology was only taught as a subject at universities and colleges of education. The milestone marking the maturity of psychology in Viet Nam was when the Faculty of Psychology and Pedagogy was established at Hanoi University of Education in 1965. In the late 1990s, clinical psychology gained attention, and students at schools with training in psychology were sent to Western countries to study. There are several psychology training facilities and some agencies have teachers and trainers been educated in US (St. John's University, Vanderbilt University) like Hanoi National University of Education and Viet Nam National University, or France (University of Toulouse II le Mirail) like University of Social Science and Humanities, some have collaborate and published many international articles like Hoa Sen University so today’s programs and students are mostly updated with global knowledge. Nevertheless, this career wasn’t noticed and did not have any influenced until the Ministry of Education and Training (MOET) of Viet Nam issued an official correspondence to all K–12 schools on April 4, 2005, and later on May 28, 2005 recommending the implementation of vocational and psychological counseling services to both upper and lower high school students in order to address the mental health and behavioral needs of school-age children (MOET, 2005). Recently, the Vietnamese Prime Minister signed Decision No. 34/2020/QD-TTg promulgating the list of occupations in Viet Nam, which identifies the title of Psychologist (vocational code 2634) with specific descriptions of a number of positions and main duties, for the first time. It is big news for psychologists in Viet Nam as this career is recognized by the government.

Based on the data in 2017, generally, in the country, there are 36 mental institutions in the Viet Nam with a combined capacity of over 6,000 beds. The Ministry of Health and the Ministry of Labor, Invalids, and Social Affairs have reached an agreement on the treatment and care of a large number of people with persistent mental diseases, with the approval of the government. To treat social diseases and care for chronic mentally ill patients, most provinces establish mental hospitals or Prevention and Control Centers for Social Diseases, specifically, 20 hospitals and 12 centers in the North and 11 hospitals and 21 centers in the South. Until that time, there were approximately 900 psychiatrists operating in the psychiatric system across the country.

As a part of my Master course, I had an internship in National Institute of Mental Health - Bach Mai Hospital - one of well-known establishment in treatment for mental illness patients in Viet Nam and a gathering place of leading experts in the field of psychiatry, a reliable address for undergraduate and graduate training in psychiatry across the country. With a total of 187 hospital beds, the Institute annually admits more than 3,000 patients to inpatient treatment with acute mental disorders and maintains outpatient monitoring for more than 50,000 patients each year. Currently, the Institute has 9 functional departments responsible for examining and treating mental illnesses. The Department of Psychiatry for the Elderly do consult and inpatient treatment for patients 60 years of age and older with old-age mental disorders such as depression, psychosis, dementia. The Department of Substance Addiction Treatment has the task of: Counseling for treatment of drug addiction, alcoholism, game addiction; Inpatient treatment for detoxification of drug and alcohol addiction; and Anti-relapse treatment. Clinical Psychology Department has 2 psychologists with the following functions and tasks: Psychosocial rehabilitation for patients with mental disorders, psychological counseling, and psychotherapy (relaxation therapy, group therapy, etc.) for patients with stress-related disorders, counseling when the patient is discharged from the hospital, helping the patient to adapt and reintegrate into the community. The Department of Child Psychiatry does screen and works with children with ADHD, autism, conduct disorder, mental retardation, tic disorder, etc. Others are the Department of Treatment of Stress-Related Disorders; Department of Mood Disorders Treatment; Department of Schizophrenia treatment; Department of Functional Exploration and Outpatient treatment Clinic.

National Institute of Mental Health - Bach Mai Hospital

When getting into the hospital, the procedure will go in this way. People come to an outpatient treatment clinic, where a doctor would ask them some screening questions then direct them to the Clinical psychology department; or Department of Functional exploration; or both. In the Clinical psychology department, the patient needs to do some tests (MMPI, Zung Self-Rating Anxiety Scale, Beck depression inventory, …); and in the Department of Functional exploration, they will test EEG (electroencephalogram). After that, the result will be given back to the doctor to have further direction or prescription – inpatient or outpatient - being monitored or just having medicines. Similar to Nepal, antidepressants and antipsychotics are being used a lot, especially the new generation medicine. Regarding people staying in hospital, doctors usually visit and check them out one time a day, asking about their symptoms and re-prescribed if needed. Some of the patients also have sessions with psychologists but it’s not always the case.

Religion and mental health in Nepal

It is important to be aware that both contexts presented are in low- and middle-income countries. This affects the availability of resources. The status of mental health will be different according to the context you investigate. In the contexts of Nepal and Viet Nam there are some differences and some things that are similar. It is interesting to look more at some aspects in the different countries, once again starting with Nepal.

Religion, spirituality and culture are influencing the mental health of people and how we relate to and work with mental health. In Nepal Hinduism is the largest religion and is an important part of the culture in the country. Buddhism is also widespread in the country. In Hinduism mental illnesses can be seen as Karma from a past life. Hindus see their bodies as a belonging to God and a gift from God. It is also viewed as a temple for the soul and for God. Because of this, hurting the body is not accepted. Suicide is viewed as disrespectful and sinful, and an act that one will have to suffer the consequences of in the next birth. In Buddhism mental illness is seen as mainly rooted in environmental stress and inappropriate learning.

Illustrations of religious ceremonies and temples in Nepal

We know that religion influences how people react in times of stress. There are both positive and negative ways of religious coping. Positive ways can be to try to find some good lessons from God in the stress that is being experienced, and this can motivate you to do what you can to change the situation for the better. If you can find meaning in what is happening to you, it may be easier to stay a bit hopeful. Prayer can be a normal way to deal with stress and may help to gather your feelings and thoughts. Some negative ways of coping include passively waiting for God to control and fix the situation. The problems the person is experiencing can also be seen as a punishment from God or an act of the Devil. It can lead to question God's love, and have less faith in the good in the world and the possibility to get better.

In religion we might also see focus on healthy behaviour and a good lifestyle. Through religions we can learn about good ways to live and be towards ourselves and other people. It may include how we act when meeting people, but also other things like what to eat and how to take care of yourself. The Hindu culture focuses on how your actions define you and this may lead to people being very welcoming and warm in contact with others. People in Nepal are often described as warm and friendly. The culture of helping each other and being friendly can be seen as a protective factor in the culture. We know how important social support is for the individual and it is easy to believe that the

collectivistic culture of Nepal will lead to people being very good at taking care of people with mental illnesses.

This is absolutely the case in some situations, but we can also see examples of people being thrown out of the family because of mental health issues. People can be seen as crazy or cursed when they develop mental illnesses. This is also observed in the OPD at TUTH. The word “spell” is used to describe a lot of different disorders. There is talk about panic spells and dissociative spells. This is not done because the psychologist actually believes that people are under a spell, but because this is what many people believe. By talking about it this way it makes it easier for people to understand. However, this may not help to reduce the stigma and misunderstandings about mental illnesses.

We see that culture plays an important part in how we understand mental illnesses. In some cultures, there are special ways to describe disorders, and to understand them. The ways disorders are described might not correspond with the official diagnostic manuals like DSM or ICD. It is important to be aware of how disorders are described in different cultures to get an understanding of what people believe. It will help to meet the people in a culture specific way. There can also be culturally specific ways to treat the illnesses. We observe different methods of treatments used by indigenous healers in Nepal. On the primary level we see Phukphak Jharne, which is blowing of breath into the body, Bali, which is a small sacrifice of animals, Tantar Mantar, wearing healing amulets and Puja, worshiping God. On the secondary level we see Chinta basne, using the tantric cosmos for special possession effect and also Referral, if the case is beyond the capacity of the healer. We see that a lot of these methods differ from methods used by educated psychologists, but it is important be aware of the value of traditional healing as well. For some, it might help to meet with a traditional healer, but it is also important to be aware of the need for more specialized help for people with illnesses.

Lastly in this discussion regarding spirituality and culture we find common ground both in this field and in the field of many psychologists. This is mindfulness. Teaching techniques of mindfulness and focusing on how grounding- and breathing-exercises may help in times of stress are common in Nepal and in many other countries. This example reminds us that even though there are a lot of differences between the field of psychology and things that are common in the culture of Nepal we find some common ground, and a good intention to do what we believe will be helpful for the individual who is struggling.

Discussion about Teaching Hospital

Following this look at how religion and culture influences the field of mental health, we can move on to focus on the situation at TU Teaching Hospital. We understand that the work being done at this hospital is important and inspiring. The hospital is pioneers in the field of mental health and is doing an important job for the people in need of support.

However, different things may be seen as problematic with the facilities here Firstly, we can look at the confidentiality of the patients. At the OPD it is easy for patients to listen in on the conversations of others. The doors between the different rooms are usually not closed, and there is a constant rush of people in and out of the room, while patients are talking. It seems that the patients are okay with the situation but it may be logical to think that a calmer and safer environment would be beneficial while talking about private matters.

When the students have finished with the conversations with the patient, they go and discuss the case with a psychologist or psychiatrist, to get advice on what treatment to offer and what diagnosis to give. Sometimes these discussions are happening in front of other patients or close enough for the patient being discussed to hear. This may not be the optimal way to ensure that the patient's rights and confidentialities are being taken care of.

Further we can look into the “do no harm” principle, which is very important when working with people. There is no reason to believe that the staff at TUTH are doing anything to willingly harm the patients, but it could be discussed that the excessive use of medication could possibly do harm to patients. We know that medications such as antidepressants and antipsychotics have several negative side effects. This puts the staff at TUTH in a difficult position, because, as discussed earlier, people often expect to get medication when they search for help. During conversations with some of the students at the hospital, it seems that they try to give the medication with the least possible side effects. This implies that they are aware of the problem and want to do what they can to not harm the patients.

These issues being discussed above are basically problems as a result of lack of resources. It is hard to imagine how being less than 40 psychologists in a country of 30 million people. We seethat the field of mental health is small, but the people working within it are engaged and motivated. It is important to be aware of the huge workload these people are under and think how to care for the helpers. With the huge numbers of people struggling, there may not be as much time as wanted to take breaks and do what is needed to take care of oneself.

Even though the number of clinical psychologists in Nepal is still very low, we see that there is a change in attitudes towards mental health. The long lines of people waiting at the OPD indicates that many believe that psychologists and psychiatrists have something to offer when it comes to mental health problems. The people working in this field are inspiring and engaging, as they dare to stand in the frontline in spreading information and awareness about a topic which is taboo to talk about. At the Teaching Hospital both students and professors put in a lot of effort to learn as much as possible and to contribute the way they can to cover the needs of people. Even though there are things to improve in the mental health field of Nepal, the people that use their energy and time to work on this makes it possible to believe in a bright future for the field.

Discussion about religion and mental health in Viet Nam

Viet Nam is not as religious as Nepal since just about 26% of the population have an official religion. Still, most families view Confucianism, Taoism, and Buddhism (The three religions) as national rites and philosophy. Confucianism prioritized social ties, behavior, and harmony. Its spiritual component is based on the ideas of ancestor worship, filial piety, and moral self-cultivation. Taoists emphasize a unique perspective on harmony and balance that applies to the entire universe, in keeping with the trend toward religious mutualism. Buddhism, specifically the Mahayana school of Buddhism, stresses engagement with the world through acts of compassion to alleviate others' suffering and self-cultivation to reach enlightenment. In the face of life's problems, Buddhism emphasizes fate, inevitability, and acceptance of personal and societal suffering. These religions have been so ingrained in Vietnamese society that their values have become part of the structure of the country. That being said, the fluidity of various components of Viet Nam's religious traditions has an impact on how people think about mental health and mental illness.

The three religions in Vietnam

When it comes to ways to deal with sickness, especially mental illness, the Vietnamese have different approaches. As a collectivist society, Vietnamese support each other by taking care of and sacrificing for others. Sacrifice is a core cultural value that parents would do for their offspring and make a good example, remind them about filial behavior. It is the other way around with the youth, representing Confucianism's strong influence on Vietnamese culture, young caregivers frequently defined their motive for providing care in terms of filial respect and devotion. Caring for an elderly parent or family member was viewed through the lens of a culturally imposed moral obligation on the part of the younger generation to care for the elderly. This is also seen as a manner of pleasing and receiving the blessings and acceptance of the ancestors. For some people, mental disorders are caused by one's thinking too much, especially the elders. This contrasts with peace in mind and likely, they seek for the solution by listening to Buddhist scriptures or go to the temple to pray for peace. The advantage when working with these clients is mindfulness, which originated from Buddhism, is easily adapted, and followed for them.

In different circumstances, Vietnamese has the idiom that “If you have an illness, you should bow to the four quarters” meaning when you get ill, you should look for solutions in many doctors or places. Although it speaks to the caregivers and patient's desire and determination, it can cause the patient to worry too much, cost lots of money and lose their insight. Having discussed with psychologists and psychiatrists, they shared that there are many patients who are too worried, treat in a hurry, use too many drugs and treatments at the same time leading to overdose, or patients’ exhaustions. For instance, in order to recover quickly, besides psychological therapy, a patient also gets herbal/ traditional medicine, acupuncture and has his/her parents go to fortune tellers to “cure” depression.

Closing thoughts

After looking into the field of mental health in Nepal and Viet Nam we have seen that there are both similarities and differences. We see that the influence of religion is different in the two countries, but we know that culture influences the mental health field in all contexts. Viet Nam may be viewed as more developed in the field of mental health, with more people working in the area and more facilities available for people struggling. We know that Viet Nam is more developed than Nepal, so this can be part of the explanation. But we hope that Nepal is thriving to get closer to meeting the mental needs of the people.

It has been fascinating and interesting to get the chance to learn more about mental health and mental health conditions in general and in specifically Nepal and Viet Nam. Since there still only a small amount of research on mental health in the two countries, further studies should be addressed. However, to be able to observe and discuss these questions have been an unique opportunity to develop our understanding of this field; and we are looking forward to learning even more in the future.

CHAPTER 3

Human rights and stigma

By Julie Erichsen, Le Thi Huyen Trang & Ella Marie Roll-Hansen

Human rights are the rights people have by just existing as human beings. These rights are universal and therefore not granted by any specific state. Human rights are inherent to all, regardless of factors such as one's religion, language, gender, nationality, ethnic origin, skin color or status. Human rights can range from being highly fundamental, such as the right to live, to rights to have access to education, work, food, health and freedom. However, even though every person should have human rights, there are many violations of these human rights all around the globe regarding people with mental illness. Through our work in Nepal and Vietnam we have witnessed human rights violations of people with both mental illness and physical illness like COVID. We have seen the consequences it may have for the individual as well as on a societal level. A lot of knowledge has been gained by us through our global mental health- and crisis psychology course as well as meeting different organizations such as KOSHISH, a National Mental Health Self Help Organization and Transcultural Psychosocial Organization (TPO) in the field. This, in addition to the already existing and development of ethical principles and legal documents, makes us hopeful for change regarding this worldwide issue.

Human rights and violations of them

The first legal document to make the fundamental human rights universally protected is the Universal Declaration of Human Rights (UDHR), adopted by the United Nations General Assembly in 1948. This still to this day creates the foundation of all international human rights laws. It contains 30 articles that work as principles for all human rights conventions and treaties both current and in the future. Three of these articles (one, three & five), are representing fundamental human rights that are especially often violated with people with mental illnesses. Article 1 states that “All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” Article 3 states that “Everyone has the right to life, liberty and security of person.” And article 5 states that “No one shall be subjected to torture or to cruel inhuman or degrading treatment or punishment.” (United Nations, 1948).

There is a principle of universality of these human rights that assures that all are equally entitled to them. Human rights are also inalienable. This means that they should not be taken away from the person. However, there are exceptions in specific situations, such as the rights of liberty can be restricted if a person is found guilty of a crime by a law court. Human rights are also indivisible and interdependent, which means that one set of rights cannot be enjoyed fully without the other human rights.

People with mental illness on a global scale are being exposed to gross human rights violations daily both within and outside of the psychiatric institutions. Examples of these violations can be denial of their marriage, procreation, employment, and education, in addition to experiencing malnutrition, physical and psychological abuse, and negligence. These kinds of actions towards people with mental illness will only worsen their mental health, which will lead to even stronger vicious actions towards them. This creates an evil circle that is difficult to break out of for the people involved.

> ***"In one country, people are locked away in traditional mental hospitals, where they are continuously shackled and routinely beaten. Why? Because it is believed that mental illness is evil and that the afflicted are possessed by bad spirits."***
>
> ***"Children [are] tied to their beds, lying in soiled beds, or clothing, and receiving no stimulation or rehabilitation for their condition."***
>
> ***"Countries continue to lock up patients in 'caged beds' for hours, days, weeks, or sometimes even months or years…A couple of patients have lived in these devices nearly 24 hours a day for at least the last 15 years."***

These are some examples of how people with mental illness are sometimes being treated from The WHO Resource Book on Mental Health, Human Rights and Legislation.

Stigmatization of people with mental illnesses

Human rights violations of people with mental health issues are happening because of stigma, prejudice, and discrimination against them. Stigma is when someone is viewing a person in a negative way because the person has a distinguishing characteristic that they think is a disadvantage in life mentally, physically, or socially. According to Rüsch et al. (2005), the cause of stigma comes from three common mistakes about people with mental health problems “they are homicidal maniacs who should be feared; they are rebellious, free spirits; or they have childlike perceptions of the world that should be marveled”. People with mental illness have different thoughts, feelings, and behaviors than neurotypical people. This may make people without mental illness feel unsafe when interacting with people who have more unpredictable expressions than them. Some people who suffer from mental illness can engage in self-harming or aggressive behaviors like committing suicide or hurting people when influenced by drugs, which reinforces the public belief that they can cause harm to themselves or others. In addition, due to cognitive impairments connected to their mental illness they can be at risk of poor academic and work results. Some may be dependent on help from others to maintain function in their life. As a result, this labeling of low value and being potentially harmful lead to promoting stigma against people with mental illness.

Stigma can be categorized into public stigma, self-stigma and institutional stigma. Public stigma involves negative attitudes that other people may have about mental illness, like for example accusing them of being responsible for their own medical condition. This can lead to self-stigma, which is an internalized shame that people with mental illness can have about their own condition and therefore think that they will never be able to improve their situation. This can lead to low self-esteem and ultimately to self-isolation which creates further damage for the individual. Institutional stigma is more systematic, where policies of government and organizations intentionally or unintentionally make it more difficult for people with mental illness to get the same opportunities as those without.

Stigma often comes from a lack of understanding of the person's situation or fear for what harm they might do. This can be both subtle and it can be obvious, either way it can have damaging effects for people with mental health issues. For example, they may not seek help because of it. More than half of people with mental illness do not receive help for their disorders partly because they have concerns about being treated differently by others and are afraid of losing their livelihood. More harmful effects are that people close to them have a lack of understanding of them, they have fewer opportunities for work, education, social activities and finding a home, or being a victim of physical violence or harassment. Therefore because of these consequences, stigma is a very difficult issue in mhGAP (mental health gap action programme), which is WHO’s action plan to scale up services for mental disorders in countries especially with low and lower middle incomes. In conclusion, stigma is not helpful for either people with mental health problems or for society because it prevents individuals from recovering and to return to normal life.

Human rights' perspective on mental health in Nepal

Despite massive efforts to reduce poverty and promote economic growth, Nepal remains one of the poorest nations in the world. There is a strong link between mental health and poverty, and the economic hardship resulting from the inadequate realization of the rights to housing, food and water, political rights, economic security, education, and work among other human rights. Living in Nepal we have witnessed poverty and people who are far from meeting basic needs like these. Ill health can keep us from going to school or to work, from attending to our family responsibilities or from participating fully in the activities of our community. Hence, to promote mental health it is key to implement strategies, actions, and interventions with a human rights-based approach.

In addition to being a low-income country, Nepal is spending only a small part of their health budget on mental health. In fact, less than 1 percent of public spending's on health is used for mental health, or less than 0,03 percent of total public spending's (S. K. Regmi et. al., 2009). The mental health sector lacks adequate mental health professionals and treatment facilities, but also community-based interventions, strengthening mental health where people live. Work on promotion and prevention in mental health is necessary to reduce poverty and increase the well-being of the population. In order to improve this, it is imperative to raise awareness, increase manpower, and strengthen infrastructure and funding.

To strengthen living conditions and ensure human rights for the people of Nepal, mental health is key. Advocacy and policy work is necessary to create awareness that mental health is crucial to reduce stigma and enhance the well-being of the population. The Government and its partners need to prioritize mental health on a larger scale, both in policies and funding. Development is not only a question about the Gross Domestic Product (GDP), but also having a population that can face challenges. We need to help make the Government, partners, NGOs, and the society at large more aware of the current mental health challenges in order to find relevant solutions. Without more awareness there will not be enough resources.

Despite a lack of resources, some promising initiatives exist. We have met and talked to both governmental and non-governmental organizations working hard to improve mental health and well-being for the people living in and outside of Kathmandu. They are also working to reduce stigma associated with mental health problems. It is clear that there are many motivated and passionate people in Nepal doing what they can to strengthen the inhabitants' mental health, resilience against challenges and strengthen their well-being. In addition to treating those who already have mental health challenges, preventive measures should be taken. This includes task shifting, providing courses on dealing with for example traumatic reactions, and developing manuals to guide others in this kind of work.

However, people's mental health should not depend on these organizations alone. The work of passionate souls is important, but in order to have sustainable systems promoting mental health, they must be integrated as a part of the public health services, making them available throughout Nepal. In the following we will present some of the existing initiatives to support mental health in Nepal.

National Mental Health Self Help Organization (KOSHISH)

In countries with few resources, like Nepal, women are in a vulnerable position. They are more

exposed to various forms of violence and abuse than men are. Often, they are also dependent on men economically. Even though most women in Nepal work, the majority are unpaid (2020, Bulmer). All these variables make it more difficult for women to ensure independence and standing up for their own rights. Further, women being in a violent marriage or living on the streets are even more vulnerable for psychological problems, such as depression, anxiety, and neglect.

KOSHISH is an organization established to promote the rights of persons with mental health conditions and psychosocial disabilities in Nepal. A central part of the work of KOSHISH is service delivery, such as psychosocial support for women. We visited KOSHISH´s Female transit home, a temporary housing for women with mental health conditions and psychosocial disabilities. At the Female transit home, we met and heard the story of a woman rescued from the streets by KOSHISH.

> ***"I was very young when my step-father sold me into women trafficking. The persons who purchased me sent me to Calcutta for prostitution. I ran away from Calcutta and became a street peddler and a roadie and stayed on my own ever since. I never had a home ever in my childhood days. I grew up in the streets doing small chores for the passerby" (KOSHISH, 2021).***

In the end she was rescued by KOSHISH, and today she works for the same organization helping other women, at the Female transit home. It was inspiring to see the commitment and motivation of Matrika Devkota, the founder of KOSHISH, as well as the dedication to those who worked at the transit home, and those who lived there.

In addition to service delivery, KOSHISH´s work includes both advocacy and policy work. This is an important aspect when it comes to influencing the government and spreading awareness and knowledge about mental health. In order to facilitate development of sustainable, culturally appropriate, community-based psychosocial support systems, it is absolutely necessary to include governments, as well as community leaders, NGOs and development partners. Through advocacy work one can gain public support for mental health and psychosocial services being a necessity. KOSHISH follows a rights-based approach working both top-down and bottom-up. KOSHISH has decided not to receive public funding, to maintain independence regarding mental health interventions. It may indicate a dissatisfaction with how the Government influences and controls the organizations which they provide funding. This may indicate a need for improved knowledge about mental health in the Governments of Nepal.

Transcultural Psychosocial Organization Nepal (TPO)

Psychologists should strive for improving the situation on the ground and work with already existing community-based measures to improve mental health in a population. Efforts should be made to include other health workers such as nurses or doctors, but also non-health workers. Transcultural Psychosocial Organization Nepal (TPO Nepal) is one of Nepal's leading psychosocial organizations. It was established in 2005 with the aim of promoting psychosocial well-being and mental health of children and families in conflict affected and other vulnerable communities. Visiting the TPO Nepal, we got to hear about their work when it comes to providing psychosocial training and spreading awareness to rural areas in Nepal.

Stigma is a huge barrier to effective treatment and adherence as well as accessibility. We are focusing on healthcare provider stigma (...) and community stigma. When talking about stigma and human rights, involvement of people with lived experience is a must.

Dirsty Gurung, leading a project about reducing stigma in Nepal.

Through their work on acknowledging the cross-cutting nature of psychosocial and mental health issues, TPO Nepal is involved in multi-sectoral advocacy, from community campaigns, radio programs to the national level networks and working groups, working to improve conditions for people living in conflict affected areas.

Psychology students meeting with TPO. Photo/ill.: Mita Rana

Child Workers in Nepal (CWIN)

One can see a clear relation between disasters and poverty on one hand, and abuse and family violence on the other. Nepal is a country that has experienced many crises, for example multiple earthquakes, and has been hard hit by the COVID pandemic. Nepal is also a low-income country, and in 2018, the Multidimensional Poverty Index (MPI) also reported that about 29 percent of Nepal's population was multidimensionally poor. The situation may be worsened by reduced remittances, caused by the pandemic (World bank, 2020). This leads to more abuse and family violence worldwide. The situation is further worsened by the severe COVID pandemic lockdown in Nepal, increasing the incident of domestic violence traumatizing children in Nepal (Sharma, N., 2020).

Child Workers in Nepal (CWIN) is an organization that works for children's rights. The organization is one of two child rights organizations in Nepal and was the first organization in south Asia working to support children's rights. By lobbying, launching campaigns and putting pressure on the government, CWIN works to prevent children from living alone on the streets, being exposed to human trafficking, child labor, child marriage and abuse. This is done by focusing on protection, education and social integration of children, fundamental human rights.

CWIN further conducts rehabilitation programs for traumatized children. For example, they have transit homes for distressed children, one for girls and one for boys. We got the opportunity to visit Balika peace home, the home for Girls. There are 50 girls living at the peace home, and eleven adults working there. At the visit we got the impression that the girls were very calm, that they thrived and engaged in lots of activities such as dancing, singing, and drawing. They also receive education and mental health treatment and help. It was encouraging to see how low-threshold measures could help

improve the situation of the children and thus the population of Nepal. However, the number of staff is low compared to the needs of the girls living there.

In addition to a transit home, CIWIN also has a helpline for children in need. It is both a national call centre children in need can reach out to, and a place where children can get help and emergency accommodation. There are several helplines all over Nepal. After visiting the peace home, we visited the helpline in Kathmandu. We met some of the women working with answering phone calls from children. One of them told a story about a girl who called this helpline every day for two years, but who did not dare to tell or talk to the person answering the phone. Still, this person continued to talk to the girl, encouraging her to tell and reassuring her that it was safe. After two years, she dared to speak up and told that she was abused by her cousin. She then was brought to the helpline right away.

Students meeting with CWIN helpline. Photo/ill.: Pooja Shrestha

Previously in this chapter we have seen that mental health is a human right, and that there is often a stigma associated with mental problems. In the part about mental health in Nepal, we have seen that mental health has a negligible part of public spending's on health. Nevertheless, several initiatives exist that have the potential to be scaled to reach more of the people in need. A prerequisite for scaling up mental health services is increased funding. A first step to increase funding for mental health, is to convince decision makers of its importance, both to fulfill the human rights of the individual and to the society at large. For this advocacy is needed, both towards the Government of Nepal and its partners.

Nepal is not the only country where the population experiences mental health challenges related to stigma and lack of wellbeing. We will now present experiences on stigma related to mental health problems in Vietnam.

Stigma and mental health problems in Vietnam

The second wave of Covid-19 occurred in Vietnam in March 2020 when the 17th case was recorded. The patient is a young woman who returned from Europe but made a false medical declaration to avoid quarantine and stigma. She was not the only case made by mistake by not making an honest medical declaration. However, she was a rare case suffering serious internet violence during her treatment time. Virus was transmitted from her to 3 other people. So, a wave of social media outrage poured into her and her sister's social network accounts to the point that they had to make them

private. Not stopping there, many tried to find her parents, relatives to vent. The public thought that the hospital did not strictly manage patients, so patient number 17 had the opportunity to attend the opening ceremony of Uniqlo on March 6 right before the time of announcing the epidemic. There were even rumors that she was still at home or had fled abroad. Under public pressure, the press published a photo of a woman in the hospital's isolation room and confirmed that it was that woman who was patient 17. The fear of the unknown consequences caused by the virus at the time was one of the reasons producing the attack with the aim of shaming or removing her from the community. She was accused of bringing the virus into Vietnam, although authorities later announced that many other people on her flight had tested positive. The only difference is that she had earlier symptoms and was announced earlier. After recovering, the patient 17 shared the interview of her sister with The New Yorker of her shame because of bullying in treatment time. However, this resulted in a second wave hitting them, although it was smaller and finished faster than the first wave. The Patient 17's subsequent silent response may be not a positive sign, as numerous studies have shown that social isolation can lead to individual's withdrawal and more severe psychological consequences (Economou, 2021; Kato et al., 2020).

There were few national statistics on mental health prevalence in Vietnam although it is reported that the prevalence could be as high as 20% (Harpham & Tuan, 2006) or 14.2% (World Health Organization, 2021) and the prevalence in children and adolescents ranges from about 8% to 29% (Weiss et al., 2014). Similarly, there were very few reports of stigma against people with mental health problems in Vietnam while discrimination is not uncommon. The report showed that stigma remains high and could shift to a more discreet form (UNICEF & Overseas Development Institute, 2015).

This article wrote about how mental patients were discriminated in Cao Bang province for many years. After the articles of Lao Dong, he received proper treatment and improved symptoms.

As a result of this stigma, Vietnamese people shy away from talking about mental health and refuse treatment. Traditional Vietnamese culture considers mental health as a part of physical health, so the diagnosis and treatment of diseases are associated with physical diseases, in which neurological diseases are common. Some Vietnamese believe that Gods are related to their mental health and use religion and faith to improve their image in the community.

"The mother of my patient denied her daughter's depression. She thought that if the child is diagnosed with a mental illness, it will be very difficult to get married when she grows up. She wanted to take her child to the shaman because he confirmed her child is a shaman, so the child had to present in front of and register with him to recover from the illness."- L.T.H.T, psychologist

Stigma does not only cause an individual's mental health problems but prevents children from approaching the education system. Although many children have mental health problems that affect their access to education, there are very few special education institutions with the appropriate equipment and human resources to serve them. While schools are encouraged to offer inclusion classes for people with disabilities or mental health problems, many teachers are not trained to be ready to accommodate these students. Many parents and students have expressed their refusal to participate in class including a student who is a person with mental health problems. This causes many children with mental health problems to drop out of school. For those children who continue to attend school, they face academic pressures far beyond their capabilities and the stigma of peers or teachers.

Efforts to anti-stigma in Vietnam

In Vietnam, there are only a few legal documents providing for penalties for discrimination cases such as Decree No. 167/2013/ND-CP, Decree 117/2020/ND-CP, Decree No. 28 2020/ND-CP. However, the level of punishment may not be commensurate with the violation, while there is not much information about the actual handling of the perpetrators. Measures to educate and communicate to the public have also been implemented but their contents have not yet been able to attract the attention of the people. Therefore, the effectiveness of anti-stigma for people with mental health problems is still very limited. Mental health facilities are also trying to improve service quality to attract patients, including several high-quality private facilities. Besides psychiatrists, psychologists are also more used in some hospitals to participate in the treatment of patients. Education programs for patients and family members are also organized to raise awareness and combat self-stigmatization. However, the educational content for patients and caregivers is also limited, and the programs are not continuous.

The Vietnamese government is also working to reduce stigma and improve mental health care in schools. The event marked an important milestone when the Ministry of Education and Training issued Circular No. 31/2017/TT-BGDĐT on 18/12/2017 guiding the implementation of psychological counseling for students at school. As a result, many schools have psychological room and staff working to support students and to advise teachers who work with students with mental health problems. In general, the effectiveness of school psychology is better in urban areas than in rural areas. Because human resources for psychological counseling are more abundant in urban areas than in rural areas.

A psychological session at Nguyen Binh Khiem school in Hanoi Capital.

However, mental health isn't still considered a national health priority in Vietnam yet. Only schizophrenia, bipolar disorder, and epilepsy are of interest and the budget for mental health services is modest (Ngo et al., 2014). So far, the draft National Mental Health Strategy has been drafted since 2015 but has not been approved yet. Therefore, the budget for training, personnel recruitment, procurement of facilities as well as the budget for mental health communication is very small. During the Covid-19 pandemic, priorities for the care of cases of physical illness have been reinforced. This leads to low public awareness of mental health and perpetuating the stigma against people with mental illness in the community.

Promulgating and implementing overall strategies to combat discrimination against people with mental health problems remains a challenge for any country. Many solutions to reduce stigma today are local, although it is a global problem. Basically, it may not be able to meet the needs and emergencies. Rüsch et al. (2005) suggested anti-discrimination based on three main strategies including protest, education, and contact. Accordingly, protest is used to respond to stigmatizing public statements, media reports and advertisements; education programs provide contradictory information; and the effects of education on reducing stigma can improve thanks to contact with persons with mental illness (Rüsch et al., 2005). In addition, consultation with Schizophrenia's anti-discrimination program (World Psychiatric Association, 2005) is necessary to save time and resources.

Challenge to anti-stigma in Vietnam

As in many other developing countries, combating stigma is a challenge of the mental health care system in Vietnam. That is, there is not the National Strategy on Mental Health Care with a stable budget and human resources yet. This affects the effectiveness of therapy and communication. The low effectiveness of treatment reinforces the belief that mental illnesses are incurable and there is little chance of recovery for people with MH problems to return to a normal life. Because the effectiveness of therapy is not high, it does not involve patient and public participation, which leads to the loss of opportunities for proper communication about mental health. This is what perpetuates the stigma against people with mental health problems.

Currently, it is very difficult to attract trained human resources to participate in mental health care in Vietnam. The number of highly qualified doctors is low. Because the income of caregivers of people with mental disorders is very low and their status is not appreciated. Meanwhile, the role and therapeutic involvement of psychologists in the mental health care system is very limited. This is different from other areas of physical health care such as obstetrics, pediatrics, oncology, orthopedic

surgery, etc. This issue raises the question of whether stigma occurs among the providers of health care services?

People's awareness and cultural habits are also challenging to reduce stigma and entice people into professional mental health services. Many mental disorders present under dysfunctional forms that are difficult to measure while the Vietnamese people's understanding of scientific information is limited. This is a good environment for conspiracy theories and unscientific statements. Meanwhile, religious activities and religious leaders are playing a certain role in alleviating some of the symptoms of some disorders such as anxiety and depression, which are very common today. This further strengthens the people's belief that their mental health is spiritual issue. Many think that it is religion, but mental health facilities, can help them get through their illness. If education and the healthcare system change slowly, trained therapists will still have to compete with shamans for the trust of their patients.

The Do no harm- principle

After emergencies caused by natural disasters or armed conflicts, there is a strong need for mental health and psychosocial support on a large scale which can come from many different places of the world. Emergencies on a large scale creates both physical destruction as well as social and psychological suffering, like losses of homes and loved ones, displacement, and family separation, in low- and middle-income countries like Vietnam and Nepal where most disasters like these occur. There is a positive development in that there is increasing evidence for the efficacy of different psychological interventions when addressing the consequences of trauma. However unfortunately, different psychological approaches can sometimes be used in ways that can cause unintended harm for the people affected. Examples of ways these methods can be wrongly conducted is that there can be contextual insensitivity to issues such as security and the coordination of humanitarian aid. There can be used outsider approaches like individualistic orientations that may not fit the context or culture presented in the situation. There may also be too much focus on different deficits in addition to victimization that may contribute to undermining people's resilience. Often there is also used short term unsustainable methods that makes it difficult for the victim to cope with its challenges after the humanitarian aid has left because of the dependency that has been created. People affected by emergencies are especially vulnerable, and in some cases, there have also been the existence of doing deliberate harm both physically and psychologically of the affected people by humanitarian aid which is a gross violation of their human rights.

To be able to avoid problems of unintended harm one should follow the principles of do no harm in the code of conduct, which is a set of rules the employees within an organization should follow and use to lead their behavior. One should use critical self-reflection before, during and after each emergency response on how to prevent or minimize harm against the affected population. One should also follow ethical guidance more specifically regarding appropriate behavior in international emergencies. There should also be a stronger evidence basis for the interventions used and improve the methods used to choose and prepare the international humanitarian psychosocial workers working in situations like these. This may minimize the unintentional and intentional harm towards the affected people which will lead to less stigma and human rights violations during and after the emergency.

International cooperation: The Sustainable Development Goals

We have discussed so far, the mental- and physical health situation in Nepal and Vietnam. However, addressing the issue of health is needed on an international scale to create a bigger magnitude. The United Nations (UN) has created a global commitment with the Sustainable Development Goals (STG) that gives hope for this. Every country committed to it, should strive to reach these goals by the year of 2030. The SDGs consists of 17 main goals and 169 sub-goals, where human rights are essential in many of them. Especially SDG 3 is connected to mental health because it aims to ensure healthy lives

and promote well-being for all people at all ages. Related sub-goals here are target 3.4 that addresses prevention and treatment, and promotes mental health and well-being, target 3.5 that addresses the prevention and treatment of substance abuse, and target 3.8 that addresses universal health coverage. Even though this last target does not specifically refer to mental health, it takes up other relevant issues that include affordable essential medicines, access to quality essential health-care services and financial risk protection. To be able to reach these goals, one first needs to address the issue of stigma and human rights violations with people with mental and physical illness. The challenge of mental health in addition to physical health such as covid, is a worldwide issue. Therefore, it is important that many different places of the world work together to be able to reach these goals and create a more worthy life and better opportunities for people affected by illness.

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CHAPTER 4

EARLY CHILDHOOD DEVELOPMENT AND MATERNAL MENTAL HEALTH

By Nora Blomkvist, Nguyen Hong Dao & Pramesh Pradhan

The topic for this chapter is early childhood development, which is a very interesting and important topic. We have chosen maternal mental health as our main focus for this chapter as mothers can play a major role during the first years of a child's life and be a great source of influence for their children's early development. The process of working with this project report has been very interesting, inspiring and provided a lot of insight on this topic. We have gathered information about the situation regarding maternal mental health in Nepal and Vietnam and focused on interventions that can be used to promote maternal wellbeing and provide care for mothers who suffer from maternal mental health issues. We have also shared our reflections and experiences through this process, and hope that you will find it interesting.

Introduction

The World Health Organization has stated that it is a human right to make sure that children have the ability to reach their full potential as developing humans. Enabling this development is also important for sustainable development (WHO, 2020). The first years can have a major effect on future years and future development. The brain develops at an enormous pace during the first few years, forming more than one million neural connections each second. The nervous system will never again develop at this pace and the first years are therefore critical for a child's development (UNICEF). There are many basic functions and skills that need to be established and these include motor and perceptual abilities, language, social and emotional skills, and the ability to self-regulate. As humans we are constantly learning and developing new skills and the foundation for the ability to learn and develop is built during the early years. Poor development as a child could therefore create a poor foundation for future learning and development (Richter, 2016).

It is estimated that individuals who experience difficulties in their early development lose about a quarter of an average adult income per year. Poor early development can also severely increase the government's spending on health and education. Statistics reveal that around 43% of children under the age of five, who live in low- and middle-income countries, are at risk of not developing properly due to poverty and stunting (Richter, 2016). The term stunting refers to impaired growth because of poor nutrition, infections, and insufficient psychosocial stimulation (WHO, 2015). In addition, poverty and stunting are not the only factors that may cause risk to health and wellbeing, and it is therefore estimated that the number of children at risk of poor development is even higher than mentioned (Richter, 2016).

There are a lot of factors that have an impact on early development. Health, nutrition, safety, responsive caregiving, and early learning are some of the most important ones. Each of these are necessary for nurturing care (Richter, 2016). Nurturing care emphasizes warm and affectionate interactions and relationships where the caregivers are sensitive to the child's needs. This form of

interaction may further create a stable environment that enhances health, nutrition, and learning in addition to protection against threats (WHO, 2020). The benefits from this kind of care extend into the entire lifespan, including improved health and enhanced learning ability (Richter, 2016). This further emphasizes the importance of caregivers and the influence they have on their children during the early years.

Focus on caregivers is an important part of ensuring optimal early development considering the important role the caregivers have during the first years. It is therefore important to support families in providing nurturing care for their children (Richter, 2016). One focus area that could improve care is maternal mental health. In 2020 WHO created guidelines for how to improve childhood development. These guidelines consisted of four main recommendations, and one of these was the support of maternal mental health (WHO, 2020). Depression, anxiety, and somatic disorders are the most common perinatal mental disorders (Hashimi, 2014). The word perinatal, if using a broad definition, refers to the period from one becomes pregnant and up until 18-24 months after birth (Helfer, 2002). These disorders can severely affect the health and wellbeing of both mother and child. Long term studies have shown that children's psychosocial wellbeing can be negatively affected by having mothers who suffer from a depressive disorder, this includes both health and socio-economic disadvantages (Hashimi, 2014). Some of the negative health outcomes for children with depressed mothers can include low birth weight, respiratory disorders, preterm birth, poor academic performance, emotional problems, and increased risk of depression for the infant (WHO, 2020). Perinatal depression has also been associated with substance use (tobacco, alcohol, and other substances) in addition to emotional, physical, and behavioral difficulties for the mother (WHO, 2020).

Maternal depression has gained recognition over the years and is now considered a major public health concern (WHO, 2020). Research has shown that stressors related to pregnancy and birth can affect both the thinking style and behavior of many mothers. This can further make it more challenging to carry out the tasks related to childcare. This change in thinking, behavior and coping can be diagnosed as perinatal depression. Symptoms of perinatal depression include depressed mood, loss of interest and enjoyment, and lack of energy that results in a lack of activity. In order to get a diagnosis, the symptoms need to be present most of the time for at least two weeks. Many mothers with depression also experience anxiety symptoms and somatic symptoms. This can further lead to difficulties with usual work and social activities due to symptoms of depression (WHO, 2015).

Perinatal depression is a widespread issue. Statistics show that 1 in 10 women in high income countries develop perinatal depression, and that 1 in 5 women develop perinatal depression in developing countries (WHO, 2015). If all these women were referred for specialist health services, it could cause a lot of issues. First, there are not enough specialists to help everyone and that could cause endless waiting lists. Second, not everyone has access to specialist health services where they live. The goal is to create interventions that are easily available and that do not take up a lot of resources. WHO is a central actor in this kind of work and they have developed the Mental Health Gap Action Programme (mhGAP) for scaling up mental health services. There is a huge gap between the number of people that need help for their mental health issues and the number of people who actually get this help. The goal of the mhGAP is to close this gap and work towards better mental health coverage all over the world. Low- and middle-income countries have a special focus in the action programme as well (WHO, 2008). An important term when it comes to working towards this goal is task shifting.

Task shifting involves shifting some specific tasks from specialists to health workers with less training and fewer qualifications (WHO, 2008). In order to do this in an appropriate way, it requires sufficient training in interventions that the health workers are able to perform. Examples of health and community workers that can be trained in mental health work are nurses, teachers, and social workers. Some programs also include training of people with high school education. There are many examples where task shifting has led to both affordable and acceptable interventions with positive

outcomes regarding both early detection and effective treatment (Hashimi, 2014). With task shifting, specialists can develop interventions and guidelines that are suitable for other health and community workers. In this way, specialists can use their competence in a more effective way and spread their knowledge much more rapidly. This also ensures that people who live far away from specialist health services can receive mental health care from people in their local community, and that the services in general are more easily available. This is also very important when it comes to reaching mothers who may need help with maternal mental health issues.

Research shows that interventions for improving maternal mental health can lead to several positive outcomes. Most interventions target depression and anxiety for mothers, and they may include elements of cognitive behavioral therapy, psychoeducation, and social support to mention some. When assessing symptoms after these kinds of interventions, several studies have shown significant decrease in anxiety and depressive symptoms (WHO, 2020). Several interventions have also proven to create better mother-infant interaction and relationships, and improve cognitive development and growth (Hashimi, 2014). Interventions that deliver psychosocial support for mothers can have a great impact. With accessible and appropriate help, it is possible for mothers to improve and overcome their depressions. This help can be carried out by workers in the local communities who can deliver the support needed for making the necessary changes and prevent later issues for their children as well (WHO, 2015). A central example of an intervention for maternal mental health is the thinking healthy manual.

The thinking healthy manual

Thinking Healthy manual which focuses on depression in the perinatal period is a supplement to the World Health Organization's mhGAP Intervention Guide (mhGAP-IG). It was designed to provide detailed instructions on how to implement the evidence-based guidelines contained in the mhGAP-IG for the management of perinatal Depression. This manual focuses on local health workers who don't need to have past information or experience of mental health. It also contains directions to help them shorten the mhGAP by managing of perinatal depression into their work.

In this manual, the key element of Thinking Healthy is Cognitive Behavior Therapy which is an evidence-based and structured form of talking therapy with purpose of altering the cycle of unhealthy thinking (cognitions), leading to unhelpful emotions and the resulting undesirable actions (behavior). With this therapy, the mother is encouraged to recall an image from real life that contains unhealthy cognitions and consequent ineffective behavior, she is then encouraged to modify the picture by thinking in a more supportive way. In this manner, utilization of pictures and creative mind can be utilized in individuals whose strength isn't verbal language. Thinking Healthy uses painstakingly adjusted representations to help the moms and families envision these pictures.

The Thinking Healthy Programme (THP) aimed to reduce perinatal depression in low socioeconomic settings and to improve health outcomes in their children through the adaptation and integration of CBT into the routine work of community health workers. Starting from pregnancy till one year postnatal, participants received 16 sessions of the evidence based "talking therapy". The sessions combined the therapy with activities to improve maternal well-being, mother-infant interaction, and maternal social support.

Thinking Healthy breaks down these CBT principles into 3 simple steps. Each session employs the three-step approach that is repeated throughout the program. Step 1: Figuring out how to distinguish unhealthy thinking: In request to advance positive reason, know about the normal kinds of undesirable reasoning styles that slowly create because of life issues or encounters. Using carefully re- searched and culturally appropriate illustrations, mothers are educated about such unhealthy thinking styles and learn to identify them. Step 2: Learning how to supplant undesirable thinking with supportive

reasoning: Identifying such unhealthy thinking which empowers moms to inspect how they feel and what they make in this way. Step 3: Practicing Thinking and Acting Healthy: The intervention suggests activities to help mothers practice helpful thinking and more helpful behavior. Through 3 steps, this manual focuses on helping mother negotiate each of these 3 areas: Mother's well-being; Mother – infant relationship; Relationship with people around the mother and infant. There are 5 modules including 19 sessions and each module contains sessions to address problems within those areas. After the introductory session, each session is divided into 4 tasks that a CHW is asked to carry out with the mother and family: Task 1: Review key messages from previous sessions, task 2: Review the mood chart, task 3: Conduct 3 steps to THINKING HEALTHY focusing on the area designated for the session. When conducting the training based on this manual, people should note that: The duration should be from 5- 10 days. The maximum number of participants should be 15 and it should be implemented by a pair of trainers.

Here is A proposed timetable of the Thinking healthy sessions:

MODULES	SESSIONS	IDEAL FREQUENCY	APPROXIMATE PERIOD
Introductory session	Opening Session	Delivered in 1 or 2 visits	14 – 40 weeks prenatal
Module 1 Preparing for the baby	Sessions 1.1-1.3	Weekly	14 – 40 weeks prenatal
Module 2 The baby's arrival	Sessions 2.1-2.2-7	Fortnightly	3rd to 5th week postnatal
Module 3 Early infancy	Sessions 3.1- 3.3	Monthly	2nd to 4th month postnatal
Module 4 Middle infancy	Sessions 4.1- 4.3	Monthly	5th to 7th month postnatal
Module 5 Late infancy	Sessions 5.1- 5.3	Monthly	8th to 10th month postnatal

After being implemented in many countries, the intervention has been evaluated in one of the largest randomized trials for psychological interventions to be conducted in the developing world. In a rural Pakistani population of 1.2 million, about 4000 pregnant women were screened to identify 903 with perinatal depression. Besides, in partnership with the Primary Health Care Services, 42 Community Health Workers were trained to deliver THP. Therefore, the intervention cost under US$ 10 per woman per year, and led to recovery in 3 out of every 4 women treated.

Thinking healthy in Vietnam

Recently, both international and Vietnamese researchers have started to conduct their work on maternal mental health. In our report, we would like to write about some of their studies.

The first one is “Emotional violence and maternal mental health: a qualitative study among women in northern Vietnam”, This research was conducted through in-depth interviews with 20 women living in Hanoi, Vietnam who had reported to have experienced emotional violence by their partners and attained high depression scores. The data were used with qualitative content analysis. Their records highlighted three especially critical components of emotional violence: being ignored by the husband; being denied support; and being exposed to controlling behaviors. These encounters impacted the ladies' feeling of prosperity significantly, causing bitterness and trouble. The study findings suggest that effective policies and programs to decrease women’s vulnerability to intimate partner violence must consider the kinship arrangements that prevail in a given society (Nhi T.T at al, 2018).

The second research was conducted by Tine M. Gammeltoft in 2018, it included a prospective cohort study of 1337 pregnant women and ethnographic interviews with selected women. Women were enrolled at antenatal consideration offices in Đông Anh area in 2014. Every woman was appointed a caseworker who talked with her multiple times: at enrolment, in the second trimester of the pregnancy, at conveyance, and 4 a month and a half later the conveyance. Their danger of misery was evaluated utilizing the Edinburgh post birth anxiety scale (EPDS), a screening device that means to decide ladies' danger of discouragement during pregnancy and later birth. During our home visits, we talked in more detail with the women about these feelings and their social sources. Overall, many women said, they felt sad, depressed, and unwell. The feelings they described fell, I found, roughly into three closely interrelated categories. First, and most commonly, they described feeling tense/strained, oppressed, and under pressure. Second, the women evoked feelings of constraint, of being caught up and having no way out: they spoke of being in an impasse. Third, they described feelings of worry, of being burdened by too many. The opposite state of being, one that many women longed for, was feeling free, relaxed and at ease. In many cases, the women’s husbands, rather than the women

themselves, were at the center of these structural conflicts. Male-oriented kinship expectations seemed to place husbands in precarious positions in at least three ways. First, many husbands were under enormous pressure to produce a male heir. Of the 24 women in our sample who had children already, 12 had no sons; 8 women had one daughter and 4 women had two daughters. In these families, the anxieties around pregnancy were intense. in sum, a pregnancy or a new child can intensify kinship tensions and conflicts, deepening men's difficulties in living up to the social and moral demands placed upon them as sons, husbands, and fathers. Women's vulnerability during pregnancy and childbirth was, in other words, inseparable from their husbands' structural vulnerabilities within kin groups. Living in the midst of unsettled domestic conflicts seemed to turn women's everyday living environments into dense and emotionally demanding zones of pressure, hostility, and tension, shaping their moods in wide-ranging ways (Tine M. Gammeltoft, 2018).

The last one in 2012, Niemi and Maria have conducted in 4 studies, two of which (study II and III) has been focused on maternal mental health). In study II, illness explanatory models of depression and postnatal depression were elicited from mothers and health workers, through semi-structured interviews. And study III, individual interviews addressing the experience of depression during pregnancy were conducted with nine women who obtained high scores in a depression self-report measure during pregnancy. The causation of perinatal depression was described as predominantly somatosocial. Psychiatric treatment was seldom recommended, and depression was described as not openly spoken of by those afflicted. The stigma of depression arose as possibly critical through the subjective examinations and common social adversities were found to be relevant for causation of perinatal depression which is associated to preterm birth. Mindfulness based interventions appear to be a locally feasible. A way to deal with misery the executives that centers exclusively around individual pathology will neglect to address these causes and, in this manner, numerous areas in the eye of public ought to be associated with counteraction (Niemi and Maria, 2012).

Thinking healthy program has been conducted recently in Vietnam and here is research about it.

First, "Translation, cultural adaptation and field-testing of the Thinking Healthy Program for Vietnam" by Jane Fisher and her colleagues, depression and anxiety are prevalent among women in low- and lower-middle income countries who are pregnant or have recently given birth. There is promising evidence that culturally adapted, evidence-informed, perinatal psycho-educational programs implemented in local communities are effective in reducing mental health problems. The THP has proved effective in Pakistan. The aims were to adapt the THP for rural Vietnam; establish the program's comprehensibility, acceptability, and salience for universal use, and investigate whether administration to small groups of women might be of equivalent effectiveness to administration in home visits to individual women. To do that, the THP Handbook and Calendar were made available in English by the program developers and translated into Vietnamese. Cultural adaptation and field-testing were undertaken using WHO guidance. Field-testing of the four sessions of THP Module One was undertaken in weekly sessions with a small group in a rural commune and evaluated using baseline, process and end line surveys. As a result, the adjusted Vietnamese form of the Thinking Healthy Program (THP-V) was viewed as justifiable, significant, and pertinent to pregnant women, and collective wellbeing place and Women's Union delegates in a provincial area. It was conveyed via prepared nearby facilitators. Role-play, brainstorming and small-group discussions to find shared solutions to common problems were appraised as helpful learning opportunities. Therefore, the THP-V is protected and conceivable, adequate, and remarkable to pregnant ladies without emotional well-being issues in provincial Vietnam. Conveyance facilitated small groups provided values gave esteemed freedoms to role-play and shared critical thinking. Local observers found the content and approach highly relevant to local needs and endorsed the approach as a mental health promotion strategy with potential for integration into local universal maternal and child health services. These preliminary data indicate that the impact of the THP-V should be tested in its complete form in a large-scale trial. (Fisher et al, 2014).

Second, in 2018, Jane Fisher and her other colleagues applied Thinking healthy manual to conduct The Learning Clubs intervention and researched it in a two-arm parallel-group cluster-randomized controlled trial, with the commune as clustering unit. An independent statistician will select 84/112 communes in Ha Nam Province and randomly assign 42 to the control arm providing usual care and 42 to the intervention arm. In this research, the intervention is an organized program joining perinatal stage-explicit data, learning activities and social help. It involves 20 modules, in 19 accessible, worked with the number of women at a public venue and one home visit. Proof informed substance is from intercessions to address each risky tested in randomized controlled trials in other asset compelled settings. Content has been interpreted and socially adjusted for Vietnam and adequacy and attainability set up in pilot testing. It is hypothesized that fewer children whose mothers participated in the Learning Clubs intervention will have Bayley Scales of Infant and Toddler Development cognitive scores < −1 SD below age-specific norms at 2 years of age compared with children whose mothers received only usual care. After being conducted, data was shown that it places an explicit focus on addressing the health and psychological needs of women who are pregnant or providing primary care for infants and young children and the principle with discussion of how in practice these are being implemented and how further changes might be made. The essential result is being surveyed by the BSID, third Ed59 Cognitive Score. Researchers have adjusted a small arrangement of items to make them unmistakable to kids (e.g., replaced the image of a donkey, which no children will have seen, with one of a water buffalo, which are widespread in the area). However, it has not been possible in this to direct a conventional approval against a pediatric formative evaluation because to do this for adequate numbers of children for each month of age requires enormous resources which have not been available. In conclusion, the data are likely to make a substantial, valuable contribution to knowledge about a low-cost, integrated, universal approach to improving the early development of young children by attending to their needs and, most importantly to the needs of their primary caregivers (Fisher et al, 2018).

Thinking healthy in Nepal

TP Nepal
PEACE OF MIND

Maternal depression is one of the major contributors of pregnancy-related morbidity and mortality in Nepal. Despite its enormous burden, maternal depression is neglected and remains under-recognized and undertreated in low-income and middle-income countries (Gelaye, 2016).

The thinking healthy manual is currently being translated and adapted to the Nepali culture. From our group, Nora and Pramesh visited TPO (Transcultural psychosocial organization) to have a meeting with Prasansa Limbu and Pragya Shrestha. Prasansa is doing a PhD in maternal mental health and Pragya is a psychologist working with maternal mental health. TPO was established in 2005 and is one of the leading psychosocial organizations in Nepal. Their work revolves around promoting psychosocial well-being and mental health, and this is done in various ways. Advocacy, education, research, and service delivery are some examples (TPO). Maternal mental health is one area of focus for TPO, and Pragya and Prasansa are working with implementing the thinking healthy programme in Nepal.

This work is done through the ENHANCE project: scaling-up care for perinatal depression through technological enhancements to the “thinking healthy programme”. The current health programmes related to maternal and child health in Nepal have a largely physical focus even though 4-20% of women suffer from perinatal depression in Nepal. Suicide is also the leading cause of death for women in their reproductive age. The ENHANCE project aims to give better mental health care for mothers through implementation of the Thinking Healthy Programme for perinatal depression in Nepal. The project will span over three years and its effectiveness in treating perinatal depression is currently being evaluated. The main part of the project revolves around adapting the manual to Nepali culture and training female community health volunteers in the manual. These workers will then be able to offer the intervention to mothers in their local communities (TPO).

Summary of the interview

Before going into their actual work. Prasansa wanted to say something about the story in Nepal and what inspired their project. Looking a decade back in time, there were only big health institutions that offered any kind of help for mental health issues. The mental health burden was still heavy, but there was a lack of both resources and knowledge. During this time, WHO created a project through their mental health gap action program that included some African and Asian countries. Nepal was part of this project that lasted for 8 years, and they received a basic mental health care package. The program was a big success, but there was still something missing. No maternal health issues were being registered. This did not mean that no mothers suffered from mental health issues, but that this was something that no one was talking about or focusing on. This was a motivation for starting a project related to maternal mental health.

Prasansa further shared that they started a study to understand how the situation was in Nepal regarding maternal mental health. They revealed that there was a lot of stigma related to these kinds of issues, and that mothers did not seek help for their mental health conditions. The only recognized maternal mental health condition was psychosis. Other conditions such as depression and anxiety did not receive a lot of focus in mothers. Because of this lack of awareness and stigma, mothers who suffered from these issues did not seek help even when there were existing offers for them. Because of this, they started doing work to create a demand for mental health services for mothers.

They used a method where you make a history with a protagonist who is experiencing mental health issues. This is described in a way that does not mention mental health directly and is adapted to the local context. This method was made to reduce stigma and give people something they can connect with. This was used in a lot of different countries, and it was decided to make these kinds of stories for maternal mental health as well. We were also given some posters with examples of the stories they have made translated into English for us.

This kind of story was later tried out in a lot of different communities in Nepal to try and increase the number of referrals for maternal mental health issues. The stories were presented for people in the communities and the mothers who connected with the stories and recognized things from their own experience got a referral to mental health services for these issues. Out of these women, 67% of them scored for maternal mental health conditions. Another project, where they trained midwives in recognizing maternal mental health issues, also made sure that more cases were uncovered.

Below are some examples of the stories they have made related to maternal mental health in Nepal:

Name: **Location:**

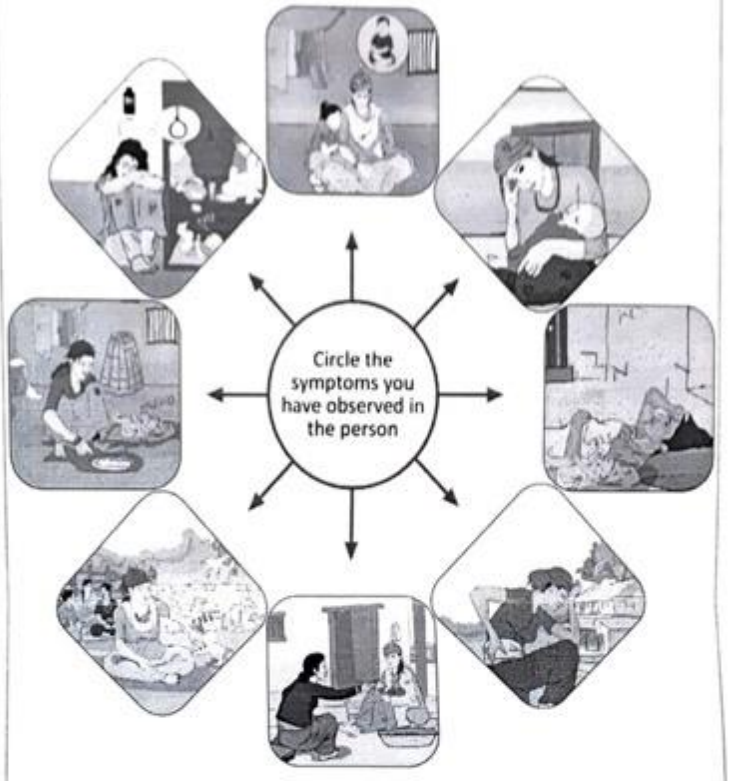
Postnatal depression

Binita is from a poor family and has just given birth to a daughter for the second time. It is just a few weeks after delivery, she looks depressed throughout the day. She has not been able to stay happy even after giving birth. In the same way, she feels guilty for not being able to give birth to a son and make her family happy. Most nights she has not been able to sleep thinking about these things because of which she feels tired and lazy during the day. Binita used to be very energetic, but nowadays, she feels weak and has not been able to carry out her household chores. Similarly, she also feels irritated to look after the newborn baby and gets angry easily with anyone. These days she stays alone most of the time, doesn't eat well and doesn't maintain her personal hygiene. Because she could not do anything as she had imagined, she thinks there is no reason for her to live.

Referred by (Name): _____

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

OBSERVATION



QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } Finished
- Moderate match (person has significant features of this description) 2
- Good match (description applies well) ..... 3 } Go to A2/A3
- Very good match (person exemplifies description, prototypical case) 4

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

Results: (Total score of items A1, A2 and A3)

TPO Nepal PEACE OF MIND PRIME HealthNet TPO

Name: **Location:**

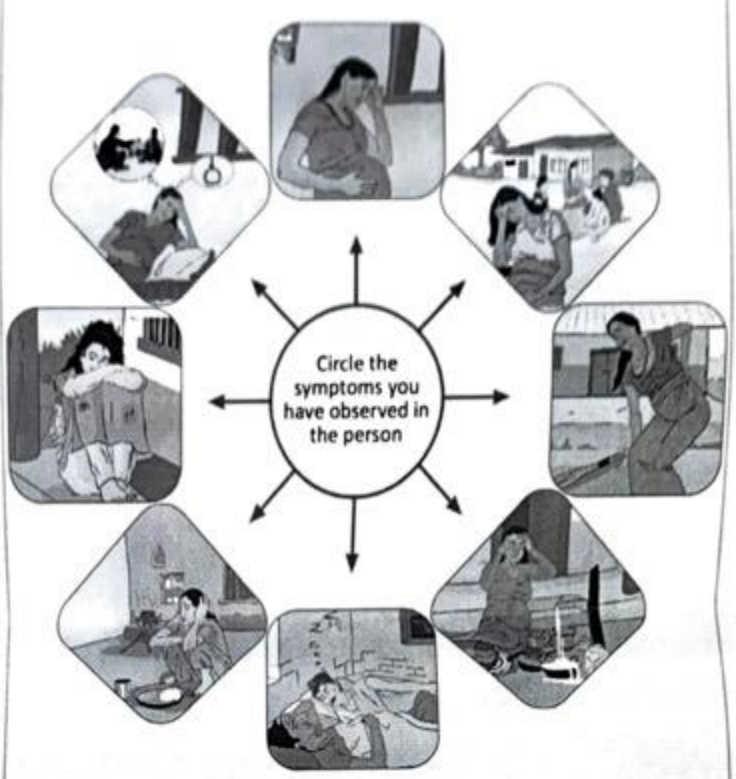
Referred by (Name):

☐ Teacher ☐ Mother's Group ☐ Traditional Healer ☐ FCHV

Antenatal depression

Sabina is six months pregnant. For the past two months she has looked depressed and has not been able to enjoy anything. Most of the time, she prefers staying alone and feels irritated upon hearing others talking to her. She complains of having pain in different parts of her body and feels tired most of the time. Despite having difficulty carrying out daily household chores, she is expected to take care of everything. She feels that her family does not understand her problem thus, feels frustrated with her life. When all these things overtake her, she feels restless and wants to run away from all the responsibilities. She has not been able to sleep and has been eating less than usual. She thinks that there is nothing she can do in her life and cries almost every day. Sometimes she thinks it is better for her to die than to live.

OBSERVATION



QUESTIONS

A1. Does this narrative apply to the person you are talking to now?

- No match (description does not apply) ..... 1 } **Finished**
- Moderate match (person has significant features of this description) 2
- Good match (description applies well) ..... 3 } **Go to A2/A3**
- Very good match (person exemplifies description, prototypical case) 4

A2. Do the problems have a negative impact on daily functioning?

- No 1
- Yes 2

A3. Does this person want support in dealing with these problems?

- No 1
- Yes 2

Results: (Total score of items A1, A2 and A3)

TPO Nepal PEACE OF MIND PRIME HealthNet TPO

Another issue with mental health care for mothers was that a lot of the mothers did not come to treatment or only went to some of the sessions they were offered. They are at the moment still in the process of researching this, but they have found some main points that may explain why the situation is that way. One reason is the distance the women must travel to come to the sessions. For many of them it took a lot of time, and it was not very practical either. Another issue is self-awareness, and that a lot of the mothers do not realize the issue and that this is something they can get help with. Many mothers also experienced that different health professionals had the sessions with them, and that they did not have one set person that had all of their sessions. This may also have caused some to quit the program.

These reasons further emphasize the importance of community-based interventions that are easily available for people in their local community. They are currently working to reach people in their homes and make the offer more accessible.

The main project that Prasansa and Pragya are working with at TPO is to translate and adapt the thinking healthy manual from WHO to Nepali and the Nepali context. They began this work in November 2020 and are currently in the process of adapting the manual. They have translated it already and have made many adaptations. Prasansa is estimating that they will be completely finished within 1-2 years. They are also testing the manual through a pilot study and are planning to do more of these.

Female community health volunteers and health workers will be central in carrying out the help that is taught through the thinking healthy manuals. Female community health workers are considered to be trustworthy and easily available in the local community. The plan is that they go through a training program so that they can provide psychosocial help in their communities. Prasansa also mentioned that they have focused on making the manual easily understandable and practical.

What are the main adaptations that have been done when adapting the manual to the Nepali context? Prasansa and Pragya went through the key points that they have changed and adapted to make the manual more suitable in Nepal. They translated it from English to Nepali and changed the pictures to fit the local context. The terms and explanations have also been adapted and changed. Few people are familiar with mental health terms and use this in their everyday language. The language is therefore adapted to make it understandable and relatable. Another difference is that the kind of worries and thought processes that women experience in Nepal are not always the same as in other contexts. This requires different examples and different ways to view some of the issues. The metaphors in the manual have also been adapted and changed to local metaphors that help with increased understanding. A lot of the mothers who suffer from perinatal depression in Nepal also show signs of anxiety, and this has gained a greater focus in the Nepali version of the manual. Domestic violence has also been added in the Nepali manual as it is a prevalent issue for many of the mothers with perinatal depression.

One thing that became a topic during our meeting was if the manual can include mothers who experience stillbirth or miscarriages. The thinking healthy manual does not address this, and it has some focus areas that are not relevant for women who have lost their children. An example of this is that a lot of focus is on the mother-child relationship. Both Prasansa and Pragya expressed that this was a group of women that they really wanted to help and that they did not want this to be an excluded group. They suggested that more grief-based interventions would be more suitable, and they hope that mothers who have lost their children will have available offers as well.

After being at TPO and having this interview, it seems like Nepal is headed in a positive direction when it comes to awareness surrounding maternal mental health and scaling up services for mothers who need care and support related to their mental health. They are still in the process of finishing the adaptation of the manual and are hoping to finish their project within the next few years, and they

report that they have a lot of positive results surrounding the training and implementation of the manual in the areas they have been focusing on in Nepal.

Summary and reflections

This report has focused on maternal mental health as an important priority when it comes to early childhood development. The first years are critical for a child's development and the enormous development that takes place in the nervous system during these years builds a foundation for future development later in life. In most cases the parents play a major role during these years, spending most of their time with the child. The caregivers can therefore have a major influence on a child's early development and because of this it can be important to focus on the caregivers to improve early childhood development. A focus on mothers and maternal mental health can further be an important part of this. Pregnancy and birth can cause a lot of stressors that can make mothers vulnerable to changes in thinking style and behaviour. This can affect their mental health negatively and possibly lead to perinatal depression, which statistics have shown to be quite a widespread issue. Interventions that provide psychosocial support for mothers who struggle with maternal mental health problems have also shown positive effects for both the child and the mother. This information has provided the foundation for our project work.

The main part of our project work revolved around the thinking healthy manual and how it is being implemented in Nepal and Vietnam. The experience of working with this project has been a great learning experience and provided a lot of insight. It is motivating to see that it works to implement this manual in different contexts and that it can be done in a cost-effective way as well. It has also been very interesting to see and experience a lot of the things we have learned about this semester like task shifting and adaptation to culture. In Nepal they are training female community health volunteers in using the thinking healthy manual. This is currently having promising results as well as making sure that this intervention is accessible and not requiring a lot of resources. It is really inspiring to see how one can use specialist knowledge, not only to provide specialized health care, but to create interventions and provide training that has good results and reaches a lot more people than specialists themselves could have ever done. This also provides a lot more opportunities and makes it possible to improve mental health services much faster.

It has also been very interesting to learn more about the process of adapting a manual to a specific culture and the considerations that need to be made. The researchers at TPO have really taken context as a starting point in their work with implementing thinking healthy in Nepal. They started out in a context where there was no demand for the service they wanted to provide with stigma and lack of awareness as some of the leading causes behind this. A lot of work has been done to solve this issue and they have been very creative and used a lot of different methods to increase awareness and reach out to a lot of people. They have also spent a lot of time changing the terms and examples in the manual to ensure that it is more fitting to the culture, and to ensure that it is possible to understand for its users. All this work has included creating stories that the women can connect with, using language that does not specifically mention mental health and mental health issues, and creating examples that are central in the Nepali culture. Doing this kind of work must have demanded a lot of background knowledge as well as creative skills for how to reach out and make a change in the country.

Thanks to the project we are doing, we have a chance to study thoroughly about Thinking healthy as well as improving knowledge of maternal mental health in both Nepal and Vietnam. By reading and analyzing those studies conducted in Vietnam, we have found out that maternal mental health literacy is still low and Vietnamese, especially husbands, lack knowledge. Therefore, they could not provide enough caring for their wives during and post pregnancy. It seems that women who are housewives have a higher risk of being suffered from household tensions and conflicts that made the entry into

motherhood a distressful experience than women who have jobs or are economically dependent. Most studies show that the mental health states of pregnant women and new mothers in Vietnam were inseparable from their husbands' structural vulnerabilities within kin groups, which is influenced from Eastern culture. We hope that, in near future Vietnamese government will implement more policies to protect pregnant women and raise people’s awareness of maternal mental health as well as more and more programs will be implemented to support women before, during and after their pregnancy

Overall, it has been very motivating to work with this project and to see that maternal mental health is an issue that is being recognized more and more. Mothers are such an important part of their children's lives, especially during the first years. Considering the stressors that can come with pregnancy and birth as well as having to raise a child in the process, it is evident that mothers deserve the necessary help and support that they need in this period to ensure that they can actually enjoy and appreciate this time in their life with a new child.

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CHAPTER 5

WHO: ROLE AND INITIATIVES

By Gracjana Plociennik, Thi Thanh Hue Hoang & Bhupendra Gurung

Introduction

The lack of mental health on the public health priority list has been the most significant impediment to the growth of mental health services. This has major consequences for the financing of mental health treatment because governments have allotted modest sums for mental health within their health budgets, and donor interest has been low. Another major difficulty is the arrangement of services. Mental health resources are concentrated in and around major cities, as well as in large institutions. Such facilities usually consume a huge amount of scarce mental health resources, separate people from essential family and community support systems, cost more than community care, and are associated with deplorable living conditions, human rights abuses, and stigma. However, both shrinking mental institutions and providing treatment in the community will be difficult. The difficulties of efficiently integrating mental health care with primary care services is the third obstacle to the growth of mental health services, which pertains to service organization. Primary health care systems are overwhelmed; they have many jobs and large patient loads, insufficient oversight and few efficient referral networks, and a sporadic supply of necessary drugs. Human resource constraints also contribute to this obstacle, since only a small number and kind of health workers have been educated and supervised in mental health treatment. Finally, in most nations, a key hurdle is likely to be a lack of good public health leadership for mental health (MHGAP: introduction. (n.d.). Retrieved, 2021).

In low- and middle-income countries, approximately four out of every five people who require services for mental, neurological, or substance-use disorders do not receive them. The World Health Organization (WHO) recently launched the Mental Health Gap Action Programme (mhGAP), with the goal of expanding care for mental, neurological, and substance use disorders. There is a widely held but incorrect belief that all mental health therapies are complicated and can only be given by highly trained personnel. In recent years, research has shown that pharmacological and psychological therapies may be delivered in non-specialized health-care settings (MHGAP: introduction. (n.d.). Retrieved, 2021).

The mhGAP-IG provides evidence-based strategies for identifying and managing a variety of priority illnesses. Depression, psychosis, bipolar disorders, epilepsy, developmental and behavioral disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm / suicide, and other significant emotional or medically unexplained complaints are among the priority conditions covered. These priority diseases were chosen because they pose a significant burden in terms of death, morbidity, or disability, have substantial economic consequences, and are related with human rights abuses (MHGAP: Introduction. (n.d.). Retrieved, 2021).

The mhGAP-IG was created after a thorough examination of the evidence. A WHO Guideline Development Group comprising worldwide specialists engaged closely with the WHO Secretariat throughout the process. With the assistance of an international panel of specialists, the recommendations were subsequently translated into clearly articulated step-by-step solutions. The mhGAP-IG was subsequently sent to a broader group of reviewers from throughout the world to

encompass all the varied contributions. Every five years, the mhGAP Guidelines and the mhGAP-IG are reviewed and modified (MHGAP: introduction. (n.d.). Retrieved, 2021).

Task shifting

Emotional difficulties account for 15-20% of global impairment, according to economists. Emotional issues are a part of the cycles of violence, social isolation, and poverty. They are not simply health issues, but also safety, societal, and economic issues. They impair individual and community resilience. No country has the resources to provide mental health and psychosocial treatment to all those in need: there is a significant demand for new, low-cost solutions. Psychological therapies are a potential new avenue in terms of efficacy and are high on the list of research priorities. Growing evidence base for psychological therapies from a broader range of circumstances (WHO, 2008).

One of the low-cost solutions is task shifting. Task shifting refers to a sensible transfer of duties among health workforce teams. Specific activities are transferred, when appropriate, from highly skilled health professionals to health workers with less training and credentials to make better use of available human resources for health. Reorganization and decentralization of health services based on a task shifting model can assist to overcome existing health worker shortages (WHO, 2008).

The justifications of implementation of task shifting include inadequate or non-existent national mental health policies; weak or non-existent procedures for implementing these national objectives, including patient and practitioner level interventions such as evidence-based clinical practice recommendations that are simply not implemented; and developing leadership abilities for general health care systems (WHO, 2008).

The aim of task shifting is to reaffirm governments', international organizations', and other stakeholders' commitment to increase the deployment of financial and human resources for the treatment of MNS problems. As well as to achieve considerably higher coverage of critical interventions in low- and lower-middle-income nations, which bear a disproportionate share of the worldwide burden of MNS diseases (WHO, 2008).

Scaling up

Scaling-up described as a purposeful attempt to enhance the effect of successful health-care interventions in pilot projects so that they may benefit more people, as well as to support the long-term development of policies and programs. Pilot or experimental programs, on the other hand, have limited value unless they are scaled up to have a greater policy and program impact. Until date, there have been insufficient practical instruction on how to continue with scaling up. The goal of mhGAP is to identify broad methodologies as well as recommendations for the scaling-up processes (WHO, 2008).

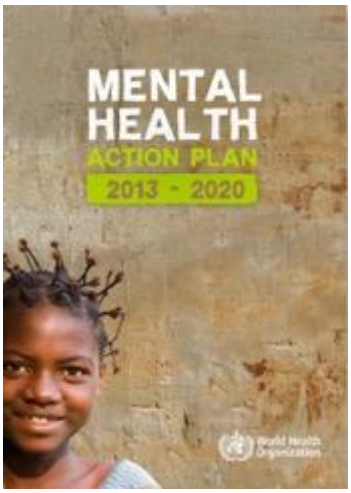
Scaling up involves the following tasks, which is identifying a collection of interventions and methods for health-care delivery, as well as designing a sequence for implementing these activities an determining the rate at which interventions may be implemented and services increased. The next is consideration of the barriers to widespread implementation of the identified interventions, as well as the possibilities for overcoming these barriers; and cost-benefit analysis of scaling up and maintaining initiatives in a variety of generalizable scenarios (WHO, 2008).

Based on evidence on the effectiveness and practicality of scaling up and task shifting, it compromises interventions for prevention and management for each of the key conditions. In this context, and intervention is defined as a biological, psychological, or social agent or activity that is designed to reduce morbidity or death. Individuals or populations might be targeted by the treatments, which were

chosen based on their efficacy and effectiveness, cos effectiveness, equity, ethical issues including human rights, practicality or deliverability and acceptability (WHO, 2008).

Mental Health Action plan (2013-2020)

Before moving to the main part of the report on the WHO Special initiative for mental health (2019-2023) we want to present mental health action plan to understand more about mhGAP and what has been done and implemented. WHO Special initiative for mental health (2019-2023) is a big and overall part of Mental health Action plan 2013-2020 (delayed into 2030). The campaign is made to help to reach the goal of mental health being a part of Universal Health Coverage, to reach more people so they can achieve higher standard of mental health, well-being, and life.



The cross-cutting principles in implementing mhGAP are drawn in this document. In general, it is the fundamental of actions related to collaboration of MH services into non-specialized health settings (WHO, 2013). In particular, the principles are summarized in the table below:

Principe	Description
Universal health coverage	- All people and communities can access the preventive, curative, rehabilitative, and palliative health treatments they require under universal health coverage, and those services are of high quality and do not put people at risk of financial harm. - Any action taken should benefit society, regardless of age, gender, socioeconomic background, nationality, race, ethnicity, religion, or sexual orientation. People with MNS problems should have access to critical health and social services to assist them achieve the best possible health.
Human rights	- People suffering from MNS are particularly exposed to human rights violations. - Providers must promote the rights of persons with MNS conditions and uphold their dignity in accordance with international human rights norms, such as the United Nations Convention on the Rights of Persons with Disabilities and national disability legislation - The World Health Organization's Quality Rights provides practical recommendations for enhancing the quality of mental health care and promoting the rights of persons living with MNS disorders. It takes a rights-based and recovery-oriented approach to care.
Evidence-based practice	- Interventions for the prevention, treatment, and care of MNS problems should be based on scientific evidence and/or best practice, considering the context. - The mhGAP-IG version 2.0 and the mhGAP operations handbook are based on mhGAP guidelines, which emphasize the relevance of scientific evidence and best practice in planning, preparing, and delivering integrated mental health services.

Life-course approach	- Mental health policies, programs, and services should take into consideration changing health and social requirements over time (early childhood, adolescence, adulthood, and old age). - It considers the importance of preventive and early intervention, as well as the United Nations SDG of ensuring healthy lives and promoting well-being for all at all ages.
Multisectoral approach	- People's social, economic, and physical circumstances all have a role in MNS symptoms. Multi Sectoral partnerships with numerous service providers in the health, education, social, and private sectors are required for a comprehensive, coordinated approach to MNS care. - The execution of the mhGAP should not result in the establishment of additional mental health services. Partnerships across departments in district governments should be developed to ensure this. • A collaborative approach at the site of service delivery is critical for the assessment, diagnosis, and management of MNS problems.
Empowerment of people with MNS conditions	- People with MNS problems should be empowered and always included, with equal decision-making regarding their care and services, without prejudice. • People with MNS problems should be at the center of their care; they should be involved in advocacy as well as policy, planning, legislation, service delivery, monitoring, research, and evaluation decisions.

mhGAP operations manual

This mhGAP operations manual (WHO, 2018) is intended to give district health managers and those in charge of integrating mental and physical health care with practical, step-by-step advice. It comes with all the tools you'll need to prepare, deploy, monitor, and evaluate mhGAP. The manual's goal is to help district health managers:

- decentralized planning in accordance with national and regional programs and policies.
- acquire the skills in scaling up services to meet the unfulfilled needs of people with MNS conditions.
- enhance existing resources and workforce capacity to achieve the greatest potential benefits of integrated MNS care.
- provide effective mental health services in non-specialized health settings.
- engage in accrediting mental health services.

The activities highlighted in this manual require a different range of skills, which are best accessed through ongoing stakeholder involvement at the national, regional, and district levels, as well as staff from development and technical agencies, universities, primary, secondary, and tertiary care, civil society, national, and international organizations that support or are interested in mhGAP. These individuals may be members of the mhGAP operations team, and they will benefit from the material in this manual (WHO, 2018).

The WHO Special Initiatives for Mental Health

Action, strategies

Establishment of the WHO Special Initiatives for mental health, covering the 5 years period (2019-2023), by Dr Tedros Adhanom Ghebreyesus, is here to give quality access and affordable mental health care within that period, in places of poverty, and poor quality of life, and health care (WHO, 2019, p. 1). It's about strengthening mental health systems to improve access and support sustainable change. As mentioned by Dr Tedros Adhanom Ghebreyesus "*nobody should be denied access to mental health care because she or he is poor or lives in a remote place"* (Ghebreyesus, 2019, p. 1).

WHO Special initiatives for mental health is a part of the overall Mental health Action Plan (2013-2030 – originally 2013-2020). As little progress was made when we came into 2020, as the vision and plan implanted in the Mental health Action plan suggested, the time got extended into 2030. The WHO Special initiatives for mental health is here to help to reach and manage the goal and vision of Universal Health Coverage for mental health.

Universal Health coverage is about all people *receiving quality health services that meet their needs, without exposing them to financial hardship in paying for them* (WHO, 2019, p. 2). It's about making it affordable, scaled up, and available to others by using task sharing and shifting. As worth mentioning, not all people will need the treatment itself, but raising awareness, empowering communities, and individuals to achieve the highest standard of mental health, well-being, and life. Actions that focus on safety, effectiveness, time, efficiency, quality and equitable, people-centered are the main part. So, the vision and goal for WHO Special initiatives for mental health is that all people achieve the highest standard of mental health and well-being. The goal is that 100 million more people have access to mental health care by 2023 (WHO, 2019, p 1-2).

The foundation of intervention WHO Special Initiatives for Universal Health Coverage for Mental Health is the value of the complexity of mental health and mental health services. It's based on (mental) health systems strengthening strategies, so focusing on what we already have, existing resources, and strengthening them. It supports ministries of health to implement and make sustainable changes, where one works directly with ministers of health. The next is the commitment of at least 5 years, as well as that it builds on in-country expertise, innovation, and resources, where one works with local consultants, local expertise, local leaders and engages all levels of WHO to support the implementation and development of the Special Initiatives over time. It engages all WHO levels of support, which are country-regional-headquarters, and encourages cross-country learning. (Alison Schafer, Personal presentation, 2012)

Originally it was supposed to be 12 countries involved in this process. Unfortunately, because of the limited/lack of funding only seven have been identified. There are: Bangladesh, Jordan, Nepal, Paraguay, The Philippines, Ukraine, and Zimbabwe.

As talked about what WHO special initiatives for mental health is about and the foundation, let's move into the implementation part, the actions itself. There are two strategic actions with different expected outputs that will be implemented to reach the vision and goal. The first Strategic action is about advancing mental health policy, advocacy, and human rights. The second is about scaling up interventions and services across community-based, general health and specialist settings (WHO, 2019, p. 2).

STRATEGIC ACTION 1: ADVANCING MENTAL HEALTH POLICIES, ADVOCACY AND HUMAN RIGHTS	STRATEGIC ACTION 2: SCALING UP INTERVENTIONS AND SERVICES ACROSS COMMUNITY-BASED, GENERAL HEALTH AND SPECIALIST SETTINGS
1. Globally, mental health is positioned high on the development and humanitarian agendas	1. Quality, affordable mental health care is scaled up across health and social services
2. Local champions, people who use mental health services, and their organizations are empowered to participate in the development and implementation of mental health policies, strategies, laws and services	2. Quality, affordable mental health care is integrated in relevant programmes (e.g. for HIV, gender-based violence, disabilities)
3. Mental health policies, strategies and laws are developed and operationalized based on international human rights standards	3. Mental health and psychosocial support is included for preparedness, response and recovery in emergencies
4. Media and community awareness about the importance of mental health across the life course is raised	4. Priority interventions for groups in positions of vulnerability (e.g. women, children, youth, older people, staff) are developed and implemented
5. Human and financial resources for mental health are brought in line with the needs	5. Implementation is documented, monitored and evaluated to improve services

Table 1. From «Ghebreyesus, T. A. (2019). The WHO special initiative for mental health (2019–2023): Universal health coverage for mental health. Geneva: World Health Organization.

In the strategies, at first, we look at all countries and the M&E (monitoring and evaluation) indicators. They have three main indicators which are access, treatment coverage, and human rights – improved attitudes to human rights approach, and common methodology to be agrees across countries and the timing. The second is more country specific M&E, which focuses on more country-specific indicators based on log frames.

The country-specific approach is the country-by-country approach. It is a tailored approach for implementation in each specific country, that is adjusted, and might differ from other countries. It helps to prioritize what is needed, and on what existing resources should one work and how to strengthen them. That is, the mental health care system, resources vary widely from country to country. The work that is needed might differ from each other, as well as also focus on the same ones. As mentioned in the presentation of Alison Schafer they experience common priorities across countries. They all have come up with similar areas that the mental health system needs to strengthen. The work really focuses on improvement of the integration. (WHO, 2019, p. 3)

Picture 1. Taken from the presentation of Alison Schafer

Challenges

As every strategic plan might experience some challenges on the way, this one is any different. Besides the point that the strategic plan was also implemented during the pandemic, they have some others as well. Making integration work is one of the challenges, as well as monitoring and evaluation. Since the implementation and since there might be differences, it is difficult to sum what should be monitored and evaluated and how. Integration is almost always one of the first challenges one experiences when working. It takes time, resources, and people, especially with lived experiences to help exchange information as well as make things work. Understanding what we are working with, the context, is the first step in making integration a little bit easier. Since different places with different context, the integration, how people work, on what, might differ. We learn from each other, but remembering that something that was implemented, and how it was implemented, might not really work in other contexts. Which again makes evaluation and monitoring slightly a challenge. The next challenge that was already met is managing short-term needs (e.g., treatment gaps) with long-term plans (e.g., mental health workforce). What one sees of what is needed to strength and change now can come in conflicts or can manipulate the long-term plans. Another very important fact and a challenge, especially during pandemic, is the careful management of an already overworked and exhausted health workforce. Other challenges that were mentioned in the presentation are the balancing supply (i.e., access) with demand (i.e., utilization) where mental health is to be stigmatized; reducing dependence on facility/institutional based care; financial management and mental health funding; and resource mobilization. As we can see there are some of the important challenges met on the way, and challenges that might affect the outcome in those different countries. (From personal presentation, Alison Schafer, 2021)

The outcomes

Let us move on to the outcome part in those different countries that were mentioned. It is worth mentioning that we do not know much yet on how the implementation works, but we got some of the information on what is been decided on what to implement and strength. Here you can see in the table all different 7 countries and their implementation (WHO, n.d). As we can see some of the countries have more information provided then others and moved quickly than others.

Bangladesh	Jordan	The Philippines	Ukraine	Nepal	Paraguay	Zimbabwe
Finalized the plan and began its Implementation in 2020. Experienced multiple challenges since then: high rates of COVID-19, monsoon rains and flooding. Last information: WHO is working with the Ministry of Health to identify elements of the newly developed plan that the WHO Special Initiative for mental health can support and complement t ensure its effective roll-out.	Firstly, Jordan's National Mental Health Plan is coming to an end in 2021. Then WHO, through its WHO Special initiative for mental health, is supporting the Ministry of Health to carry out a review of the current plan and facilitate multi-stakeholder consultations to develop its future-plan This will allow for the WHO Special Initiative for mental health and the Ministry of Health to have a single, combined plan guiding mental health reform for the next five years. Key Informant: Critical unmet needs include (1) psychosocial services and investment community services, (2) special unit for substance use/abuse, and (3) structured follow up	Moving quickly to implement its newly developed strategy. **Carried out** a mental health investment case study. It has begun implementing of mhGAP training and Quality Rights as part of pre-service training of general health-care workers in mental health. **Areas prioritized (outcomes/outputs):** (1) creating sustainable mental health governance and accountability structures; (2) increasing access to quality services; and (3) strengthening mental health research and information systems. **The Goal:** mental health is valued, promoted, and protected; conditions are treated and prevented; increased quality of life of persons affected by mental health conditions, and they can exercise their full range of human rights, supported by a strengthened leadership, sustainable accountability and inclusive governance through a whole-of-society, whole-of-	Moved quickly (just before global COVID-19 restrictions took effect) and begun implementation of its strategy, with initial focus on integration of mental health into primary care and piloting multidisciplinary community-based mental health teams. With rich collaboration with other government and non-government organizations. **Areas prioritized (outcomes/outputs):** (1) strengthening mental health governance, financing, and leadership; (2) promoting human rights of people with mental health conditions and psychosocial disabilities; (3) mental health workforce development; (4) scaling up community-based mental health services; and (5) strengthening mental health information systems, surveillance, and service evaluation, (6) mental health promotion and prevention, raising awareness and understanding, and protection.	Joined in February 2021. **Areas prioritized (outcomes and outputs)**: (1) strengthening mental health governance structures, policies and legislation, finance, and leadership; (2) promoting and ensuring rights of persons living with mental health conditions and psychosocial disabilities; (3) Workforce is equitably distributed to national, provincial, and local levels of healthcare and are quipped and supported, (4) quality mental health intervention is scaled-up and are accessible to people of all ages and with vulnerabilities, (5) strengthening mental health information systems, surveillance, and service evaluation	Has now finalized its consultation process and is soon to begin implementing its plan in three of its rural areas: Amambay, El Chaco and Caaguazú. **Areas prioritized (outcomes/outputs)**: (1) strengthening mental health governance and leadership; (2) increasing access to quality mental health services; (3) improving training and management of human resources for mental health; (4) promoting the participation of civil society in mental health reform; (5) improving research and monitoring and evaluation systems. With support from the Swiss Agency for Development of Cooperation (SDC), Paraguay will also be strongly focused on the mental health aspects of COVID-19 recovery. **The goal:** By 2013, access to quality care for mental health conditions is improved through the development of community-based services, with a	Started in 2020. Implementation began in early 2021, with plans in place to assemble national and district committees to facilitate coordinated action, undertake a mental health investment case study and roll-out Quality Rights training and tools to determine policy and legislative changes needed to promote scale-up of mental health services at community level. **Areas prioritized (outcomes/outputs)**: (1) strengthening mental health governance an leadership; (2) sustainable financing for mental health; (3) expanding access to quality and affordable mental health and allied services (including scale-up of Zimbabwe's Friendship Bench); (4) training and management of the mental health workforce and allied human resources; (5) strengthening mental health information management system and research; (6) improving the country's capacity to respond to humanitarian crises, including COVID-19.

	programs of follow up (of) persons with psychosis.	government, and health systems approach.	**The goal:** by the end of 2024, civil society and Government efforts contribute to strengthened promotion of mental health and building person-centered and recovery-oriented services, across the lifespan.		human rights and gender approach.	**The goal:** Zimbabwe's mental health system is strengthened to improve access to mental health services and realize the rights of persons living with mental health conditions.

We have learned other things about implementing the WHO Special Initiatives for mental health, besides how common some areas are for each country to focus on and to strengthen them, others were mentioned by Alison Schafer in the presentation she made. As one of them she mentions is that there are difficulties implementing national mental health strategic plans. Many countries already have international level mental health strategic plans, but often these plans are poorly disseminated or communicated. Often no funding is allocated, which makes it harder for countries to stick and follow their plans. There is shown difficulty in coordinating the messages of strategic plans from national to provincial or district level. So, the communication between partners is very poor or weak. It also seems to be this big over-reliance on facility-based care, which often is not practical enough. Often also, the strategic plans are overly strategic and lack the practical targets. Those are already many informative and useful points to be learned from, and something the WHO special initiatives for mental health is trying to address and try to avoid making the same mistakes.

Why a WHO Special initiative for Mental health?

As the definition of WHO, health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Nevertheless, MH plays an ignored role in the global attempt to enhance health. Patients with MH conditions experience worldwide human rights violations, discrimination, and stigma. More than 80% of persons with mental illnesses, including those with neurological and substance abuse disorders, lack access to adequate, affordable mental health care. Even though MH conditions account for one out of every five years spent disabled worldwide, resulting in annual economic losses of more than US $1 trillion, this is the case. It is well recognized that people with MH issues are more prone to develop other physical health problems, leading to a high rate of early mortality (about 800,000 deaths per year), which excessively affects young people and older women in low- and middle-income countries. People who have been affected by humanitarian disasters or other forms of adversity are more likely to suffer from mental health issues – e.g., sexual violence (Ghebreyesus, 2019).

Many people have advocated for mental health care in the past, but there has been a lack of commitment and financing for long-term implementation and scale-up of services. Mental health has been identified as a priority issue for expedited performance for WHO to achieve its 2019-2023 purpose of Promoting health, Keeping the World Safe, and Serving the Vulnerable. Many tools established recently by WHO, such as evidence-based guidelines, technical packages of interventions, rights-based frameworks, implementation guidance, and training resources, will aid in this implementation. In addition, WHO personnel have substantial field experience, so they know what works for promoting high-quality, low-cost mental health care and what must be done to scale up services (Ghebreyesus, 2019).

Discussion

At the end of the report, we want to mention the situation around the three countries we all are from. The case from Nepal, Vietnam, and Norway. We choose to mention topics related to mhGAP, task sharing and shifting, scaling up and the WHO Special Initiatives for mental health and the situation in particular country.

Cases in Nepal

The total number of human resources working in mental health facilities or private practice per 100,000 population is 0.59. The breakdown according to profession is as follows: 0.13 psychiatrists, 0.06 other medical doctors, 0.27 nurses, 0.02 psychologists, and 0.10 other health or mental health workers. Most psychiatrists work under the Ministry of Health, Ministry of Education (Government teaching hospitals), Ministry of Homes (Police hospitals), Ministry of Defense (army hospital) and private sector medical college teaching hospitals. Others work in private hospitals and nursing homes. The distribution of human resources between urban and rural areas is disproportionate. The density of psychiatrists in or around the largest city is 8.52 times greater than the density of psychiatrists in the entire country, while the figure for nurses is 6.56. There are no active consumer associations fighting for mental health issues in the public arena (World Health Organization, 2007).

This Child and adolescent mental health training for medical doctors and paramedical/nursing

Adolescents and children make up 42 percent of Nepal's total population. According to a school-based survey conducted among 13–17-year-old adolescents in Nepal, 13.7 percent seriously considered attempting suicide in the previous 12 months (similar among boys and girls) and 51 percent experienced bullying (56.1 percent vs 46.1 percent boys and girls respectively). More than 40% of adult mental health issues begin before the age of 14, so promoting mental health early is critical to promoting adult well-being. Early interventions for mental health problem prevention and treatment result in a much healthier and more productive later life (Arun et al., 2021).

Nepal developed its first mental health policy in 1996, with the goal of ensuring the availability and accessibility of basic mental health services for all Nepalese citizens; preparing human resources in the field of mental health; protecting the fundamental human rights of the mentally ill; and raising public awareness about mental health. The Nepal Adolescent Health Strategy 2018 includes mental health as one of the eight pillars of adolescent health response (Arun et al., 2021).

This training on child and adolescent mental health for medical doctors and paramedical/nursing professionals is based on WHO's mhGAP 2.0. This training is intended to provide health professionals in non-specialized settings with basic skills in case identification and simple local management at HPs or PHCC levels for paramedical/nursing professionals, as well as more advanced skills in case

diagnosis and management of common mental, neurological, and substance use disorders for medical doctors (MBBS and higher). This guide will be used as a preparation trainer for other Health Workers who will later be able to provide field-based training. Trainers should be a mix of psychiatrists and clinical psychologists (Arun et al., 2021).

This guide should be read in conjunction with the reference manual. Following each training for medical doctors and paramedics, there will be a separate set of participant handbooks for both medical doctors and paramedics/nursing professionals, including school nurses, to assist them in using the essential care, including communication skills, to aid in the diagnosis of the MNS condition, and to manage at their respective level. There will be a highlighted section at the end of each session on MNS condition management that deals with pharmacological management of the condition. This section will not be assigned to any professional other than a medical doctor (Arun et al., 2021).

The overall number of participants in the TOT might be in the range of 15-20. Participants in the final non-specialized group might range from experts such as pediatricians or medical physicians to paramedical/nursing professionals such as school nurses. As previously stated, pharmaceutical therapies should not be taught to nursing and paramedical professionals (Arun et al., 2021).

Diversification of training approaches is required. While PowerPoint presentations are used in each session, training should never be confined to the ppt presentation. There should be a healthy combination of role plays, video demonstration, discussion in the case vignette, demonstration by the facilitators themselves, and group discussion. There are drawings and videos available for a variety of MNS problems (Arun et al., 2021).

Cases in Vietnam

Task sharing in Vietnam: MH and psychosocial service provision through school
On December 18, 2017, the Ministry of Education and Training issued a circular guiding the implementation of psychological counseling for students in general schools, with the targets of preventing, supporting, and intervening (when necessary) for students who are experiencing psychological difficulties in their studies and lives so that they can identify suitable resolution and mitigate negative consequences, making contributions to the establishment of a safe, healthier environment.

There are two primary ways that schools can assist children and young people with their mental health and psychosocial well-being. The first is life skills training, which includes "teaching the kids about social skills, life values, self-management, and working ability; about all the different fields, understanding about themselves, about society, about relationships, about their working capacity, and guiding the children to practice all these skills," as well as "teaching the kids about social skills, life values, self-management, and working ability; about all the different fields, understanding about themselves, about society, about relationships, about their working capacity, and guiding students to apply all these skills. This instruction is given by teachers who have typically received specialized training in this area. The amount of time spent on this subject varies by school, with private schools often devoting more time to it than public schools.

School-based counseling services are the second most common technique to support mental health and psychosocial welfare in schools. However, this service is largely available in upper secondary schools and urban locations like Hanoi, Danang, and HCM City. Likewise, it appears that the large cities of Hanoi and HCMC, particularly private schools, have a broader program giving psychological assistance.

The quality of counseling services provided in schools, as well as the level of training and commitment of counsellors, tends to differ significantly, with those outside of Hanoi and HCMC being of generally lesser quality and, as a result, rarely accessed. The quality is good in the big cities. According to school psychologists, children are made aware of and have access to counseling units in a variety of ways. The counseling service can be publicized during school activities; in one school, students were given access to a fan page on a social media site such as Facebook. Teachers can also identify pupils who they believe may be having issues, and psychologists can identify students by going around the school grounds.

Cases in Norway

The funding, helping, and trying to make things better for low-middle income countries.
The knowledge and rising awareness are one of the most important roles in building up mental health, and its place in the societies. As one of the roles in building up together, is the cooperation, and in this case funding countries and programs. In this situation, Norway is funding Nepal in the WHO Special Initiatives for mental health. This funding made it possible for Nepal to participate in this programme. The person that made that call and decided in funding was the Norwegian politician Dag Inge Ulstein. He is known for his engagement in helping those most vulnerable ones. He mentions, in one of the articles, how important the case of helping the most vulnerable ones is, helping them to be heard, and to achieve better standard of mental health and living. He says, translated from Norwegian, that “the strength of a society is shown in its view of humanity, how high human dignity is held, and not least how one treats its most vulnerable” (KRF, 2021). The knowledge, awareness, and support of one another, as well and coordination on national-international-regional level is required in making thing better. In helping those who are not heard to be heard and helping others to achieve the standard of life everyone deserves. It is a human right.

We meet a lot of challenges all over the world and there is always a room for improvement. Not all of people will need the specialized treatment. Preventive and promotion of mental health, as well as the coordination will make things better. Task sharing and shifting, as well as scaling up has shown a great use for all countries of the world. It teaches the most important things one should know about mental health, raise awareness needed to get closer to understanding what mental health is about, and its importance. Many still do not know how to speak up, without being stigmatized, or judged, or misunderstood. There is still much need for support, knowledge, awareness, recognition, and normalization of mental health in many places.

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Presentation, delivered by Dr Alison Schafer, Technical Officer of the WHO Department of Mental Health and Substance use, describes the vision and uniqueness of WHO's Special Initiative for Mental Health https://www.who.int/initiatives/who-special-initiative-for-mental-health

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CHAPTER 6

SCALING UP MENTAL HEALTH SERVICES

Coordination and cooperation, role of civil society and government, specialized services and community-based services.

By Narmada Devkota, Vilde Borgen & Nguyen Phuong Hong

NEPAL

Mental health services and current challenges

Mental health services

Nepal is a country in Asia with a population of 30 327 877 people, where 12.9% of the population has been identified as having mental disorders (Haugan, 2020; Rai, Gurung & Gautam, 2021, p. 1). Mental health services in Nepal can be found in medical colleges, provincial government hospitals, and private hospitals. Tribhuvan University Teaching Hospital (TUTH) in Kathmandu is a hospital that is connected to Tribhuvan University. Students who are studying within the field of healthcare, including mental healthcare, may have their internship periods in this hospital. Both outpatient and inpatient services are provided in TUTH. A total of 25 inpatient psychiatric facilities exists nationally, and these have a combined capacity of 500 beds for people who need to be admitted. In addition, there is a psychiatry unit for children and adolescents at Kanti Children's Hospital (KCH) in Kathmandu, which currently offers outpatient services for children. At the moment, there are no inpatient services for children only in Nepal. However, a child and adolescent inpatient unit is currently being built on the second floor of the psychiatric unit. This unit will therefore be situated in the same building as the outpatient service. The services provided in Kanti Children's hospital will be explained further in later sections (Rai, Gurung & Gautam, 2021, p. 1).

Staff at TUTH and Norwegian students

KCH child and adolescent psychiatry unit

Current challenges

The existing services within mental health care are not sufficient to provide treatment for everyone who needs it, and several factors have been identified as problematic. The health budget in Nepal comprises around 6.15% of the total national budget, where only 0.2% is spent on mental health. In addition, there are major limitations in human resources, which also makes it difficult to try to reduce the treatment gap of around 90%. The treatment gap is the difference between the number of people who need treatment for mental disorders, and those who receive it (Rai, Gurung & Gautam, 2021, p. 2). In other words, the majority of people who need treatment do not receive it, which has consequences for both the individual, the community, and society.

Stigma is another major problem in Nepal. Mental health literacy, which can be defined as the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention", is quite low (Jorm et al., 1997, p. 182). Common practices include trying to conceal mental health issues, not seeking treatment, and seeking other means of treatment. Involving patients and caregivers when making decisions about treatment, as well as strengthening non-specialized services, could be a good way of reducing stigma (Rai, Gurung & Gautam, 2021, p. 2).

Another issue is the conception of mental health issues in children. The Nepalese society and health system have not yet fully acknowledged that children might have mental health issues (Luitel et al., 2015). 34.6% of the population in Nepal is children (below 14 years), which is a substantial number of people. 9.69 % is between 0-4 years, 12.10% is between 5-9 years, and 13.12% is between 10-14 years (Central Bureau of Statistics, 2011). Nepalese children are facing various difficulties due to social beliefs, persistence of poverty, gender discrimination, illiteracy, lack of awareness regarding mental health, and human rights. This needs to be addressed through comprehensive strategies for promotion, prevention, treatment, and recovery in a whole-of-government approach (Adhikari et al., 2015; Langer et al., 2019). It is estimated that about 11.2 % of the child population suffers from some form of mental health problems in Nepal (Jha et al., 2019). If children need admission to a hospital due to psychiatric illness, they have often been accommodated in an adult psychiatric inpatient facility, which is against international standards, and a violation of children rights. Such basic needs of two thirds of the children are still not met.

Availability of services is also a major challenge within mental health care. The first specialized mental health hospital for adults was established in 1984 (Rai, Gurung & Gautam, 2021). All other hospitals in Nepal were established after that and provide either general or specialized psychiatric services (Rijal, 2018). The first Psychiatry Outpatient Clinic for children and adolescents was established at Kanti Children's Hospital in Kathmandu in 2015 with the help of CWIN Nepal and partner organizations. This is a step in the right direction, but there are still only 3 child psychiatrists available in the country till date who have been providing psychiatry services. Furthermore, mental health resources are scarce in rural areas where more than 79.9% of the total population is residing (Nepal Demographics, Population of Nepal, 2020). Adult psychiatry services are somehow available at the provincial level, but child psychiatry services are almost negligible.

Despite the recent increase in clinical psychologists and other professionals in the field of mental health in general, there are still only 30 clinical psychologists in Nepal (Rai, Gurung & Gautam, 2021, p. 2). There is also only one university (i.e., Tribhuvan University, Institute of Medicine, Teaching Hospital) who is running the M.Phil. in Clinical Psychology program in the country, which means that not many psychologists graduate each year to help fill the existing gap. In addition, those who graduate are usually centralized around Kathmandu valley, so directly specialized psychotherapeutic interventions are not being received by people in their local area.

Because clinical psychologists cannot reach everyone who needs help, there is a need for interventions that make it possible to reach more people. A way to do this is by scaling up mental health services, which can be done through task shifting. Task shifting can be defined as the process where “specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications to make more efficient use of the available human resources for health” (WHO, 2008). Non-governmental organizations, or NGOs, have been crucial in this process when it comes to scaling up community mental health programs, as well as delivering mental health services (Rai, Gurung & Gautam, 2021, p. 1). Many NGOs are working in rural areas to spread awareness, advocate, provide basic psychosocial counselling services and conduct research, but they are lacking acknowledgement and funding from the government.

Scaling up mental health services in Nepal

TPO Nepal

Transcultural Psychosocial Organization Nepal, or TPO Nepal, is one of the NGOs that contribute to scaling up mental health services in Nepal. TPO Nepal was established in 2005 and provides mental health and psychosocial support (MHPSS) to communities and populations. This includes communities in general, those affected by disasters, refugees, survivors of gender-based violence (GBV) and trafficking, as well as survivors of torture. The NGO focuses on community-based approaches and collaborates with the Ministry of Health and Populations, as well as other ministries in Nepal.

Visit at TPO Nepal

TPO Nepal

TPO Nepal has stated that they are trying to close the treatment gap through service provision, advocacy, and research work. Service provision includes basic psychosocial support, focused psychosocial support, counseling, psychotherapy, psychiatric services, referral, and linkages to other services. Advocacy is about speaking on behalf of individuals or a group to make sure their rights are protected. TPO Nepal states that they are talking to the government to try to convince them to acknowledge the roles of the psychosocial counselors and emphasizes the importance of collaborations with other organizations to develop a comprehensive response to the treatment gap. Research work has contributed to the publication of more than eighty studies in journals all over the world, where some of these have been used in university classes (TPO Nepal, n.d.).

Training and capacity building is another way of closing the treatment gap according to TPO Nepal. This includes efforts to integrate mental health in primary health care settings to distribute services and reduce stigma. It also involves digitizing services and telepsychiatry, where mental health services are provided through digital platforms. In addition, people are trained in providing basic psychosocial support in communities. People who have completed high school are eligible, and those who are chosen will go through six months of training. The training has been developed by experts, and it is based on international practices. The key role of the participants is not to provide psychotherapy, and they are not regarded as experts, but they will contribute to bridging the treatment gap through linking people to services and establishing psychosocial support. This means that if community-based approaches are not enough, people may be referred to more specialized services. According to TPO Nepal, there are around 1000 psychosocial counselors at the moment. These psychosocial counselors receive supervision from psychiatrists and psychologists to ensure good quality of the services.

TPO Nepal and PRIME

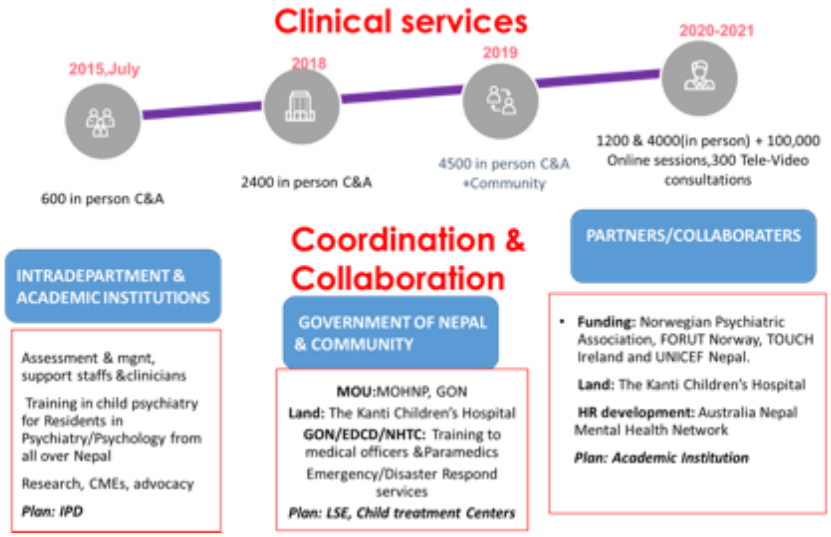
There have also been contributions from TPO Nepal in specific programs. Programme for Improving Mental health care (PRIME) was an eight-year project where Nepal, South Africa, Uganda, Ethiopia, and India were involved. The overall aim was to gather evidence regarding the implementation and scaling up of treatment programs for specific mental disorders in the context of primary and maternal health care in countries with a low number of resources. In Nepal, there was a collaboration between TPO Nepal, Ministry of Health and Populations, and HealthNet TPO. 12 primary health facilities were included, where health workers were trained in delivering mental health services for priority disorders according to World Health Organization's (WHO) mhGAP intervention guide (mhGAP-IG). mhGAP-IG refers to a clinical guide that is aimed at treating mental, neurological, and substance use disorders in non-specialized health care settings in low- and middle-income countries. Priority disorders include depression, psychotic disorders, suicide, epilepsy, dementia, alcohol- and substance-related disorders, as well as mental disorders one can observe in children (WHO, 2015). To reach more people in communities in the Chitwan district in Nepal, female community health volunteers were trained in using the Community Informant Detection Tool (CIDT) for priority disorders. The aim of the tool was to increase the ability of the female community health volunteers to detect these disorders, as well as refer people to other services if needed, which in this case would be basic mental health services from the trained health workers in health facilities (MHIN, n.d.).

In addition to the health workers, the previously mentioned psychosocial counselors were deployed to provide basic psychosocial support in communities to reach even more people. Both psychosocial counselors and health workers from the health facilities received supervision by psychiatrists and psychologists regularly to ensure that the services they provided were of good quality. This happened monthly at case conferences. Even though psychosocial counselors and health workers focused on detection and support at the community level, there was a possibility to be referred to psychiatrists at the district hospitals for patients who needed more specialized care. Furthermore, a community-based mental health sensitization program was developed to try to sensitize members of communities to mental health, as well as reduce the stigma associated with seeking mental health care (MHIN, n.d.).

Several improvements in mental health care were observed after completing the program. There were moderate to large improvements in how many people received treatment, moderate to large improvements in detection of facilities and starting treatment for people in the communities, as well as small to moderate improvements after receiving care in the clinical symptoms for people with depression, alcohol use disorder and psychosis (MHIN, n.d.).

Child and adolescent psychiatry outpatient department, Kanti Children's Hospital

Nepal has made some progress in the field of child and adolescent mental health (CAMH) in the last five years. No full time CAMH service existed in Nepal five years ago. The child and adolescent psychiatry outpatient clinic (CAP OPD) at Kanti Children's Hospital (KCH) was established in July 2015. Till today, this is the only full-time child and adolescent psychiatry outpatient clinic (CAP OPD) in Nepal. In the last 6 months of 2015, the clinic provided services to about 600 children and adolescents. In 2019, the clinic provided services to more than 4500 patients from all over the country. However, the number of clinic visits was decreased to 1200 in 2020 due to the pandemic. In 2021, the number of clinic visits has been around 4000.



Development of CAMH clinical services

This clinic provides not only on-site clinical services but is actively involved in various community outreach activities and in an overall promotion of CAMH. A CAMH Care Package has been developed, which aims to provide basic mental health services to children and adolescents at the community level. This program was piloted, and field tested in 2019 and expanded to six municipalities in Province 2 in 2020-2021, with the aim to reach more than 150,000 children. Similarly, "Life Skills Education Program" is being developed to promote resilience and mental health for school children. Over the course of the last 6 years, the CAMH unit at KCH has worked as a focal point for the development of CAMH services all over the country. It has been able to steadily progress in terms of service provided at the CAP OPD, as well as increase community outreach activities through various outreach programs. The aim is to develop this unit as a Centre of Excellence for Child and Adolescent Mental Health in Nepal that will not only provide clinical services but will also provide training and pioneering research in the field of CAMH.

Achievements and challenges in scaling up mental health services in Nepal

TPO Nepal

Achievements

TPO Nepal has shown positive efforts when it comes to scaling up mental health services in Nepal. According to the TPO Nepal website, more than 12,000 people have been involved in increasing the capacity of mental health services. This includes training in basic psychosocial support and more specialized services, and these people continue to support people in their communities. This helps scale up mental health services because specialized services are so limited in Nepal. TPO Nepal has also, as previously mentioned, been a part of PRIME. By focusing on community-based services, they have been able to reach more people, but they have also made specialized services more available for those who need more than community-based psychosocial counseling. Their work has therefore helped increase the chance of people getting the help they need. Furthermore, the female community health volunteers use CIDT, which consists of pictures and vignettes that are easily understood in populations with low levels of literacy. This may make more female volunteers able to identify priority mental disorders and could increase access to mental health services for people. Furthermore, according to TPO Nepal, female volunteers are generally accepted in the communities and often function as leaders. It could therefore be helpful in reaching more people, as people may be more accepting towards them than people from outside the communities (TPO Nepal, n.d.).

TPO has also focused on helplines and digitizing services. After the 2015 earthquake, TPO established a helpline number (1660 010 2005), which is open from 8 AM to 6 PM. Through this helpline, it is possible to provide information about which services are available for callers, as well as refer people further, without being in physical contact with them. This has been especially helpful during the COVID-19 pandemic, where social distancing has been necessary over a longer period (TPO Nepal, n.d.).

Challenges

Despite the positive efforts, there have also been several challenges. A major challenge worldwide when it comes to scaling up mental health services is inadequate support from governments, which is also true for Nepal. Interest in scaling up rarely comes from the government, which means that interest has to be generated from NGOs or funding from other sources. According to TPO Nepal, the training and role of psychosocial counselors have not yet been acknowledged by the government. TPO Nepal is therefore currently working on providing licenses to the psychosocial counselors through discussions with the government so that they can receive proper monitoring and evaluation. Because the training is relatively new, the dialogue with the government has just begun, but TPO Nepal is working on it. In addition, psychosocial counseling is not currently accepted by all members of the communities. TPO Nepal highlights that people feel that nothing happens after “talking therapy”, and therefore do not want to proceed. A possible solution may be to be proactive in this matter, and link the person to available services, as well as provide helpline numbers to communities as early as possible.

Child and adolescent psychiatry outpatient department, Kanti Children's Hospital

Achievements

A team has been built in the CAP OPD at KCH. The team is led by Dr. Arun Raj Kunwar, who is a child and adolescent psychiatrist, and consists of 16 other members: six psychiatrists, seven clinical psychologists and four other supporting staff. These contribute in the provision of CAMHS at the CAP Unit.

Several specialized services have also been improved. One example is the clinical work at CAP OPD, where outpatient services are provided to children and adolescents from all over Nepal. The staff at Kanti has also been receiving supportive sessions during the COVID 19 pandemic as a way of caring for carers. A community outreach program has been developed, as well as supportive supervision visits to the CWIN helpline. There has also been created a tele-psychiatry outreach program, which contributed by providing telephone follow-ups of patients. School mental health programs and mental health awareness programs have been developed as well, in addition to academic programs, seminars and continuing medical education at KCH. Training and supervision is being provided, and research work is being conducted. A CAMH rapid response team has been created as well. Furthermore, public announcements and awareness is currently being spread, and people are advocating for the inclusion of child mental health within the child health programs of the government of Nepal. Coordination and collaboration is constantly being worked on, and there is liaison between the CAP OPD and other departments at KCH to try to ensure more seamless care.

1. There have been improvements in community coverage as well. These include:
2. KCH CAP OPD – Work Station Kanti Children's Hospital, Coverage – Nationwide
3. The CAP OPD at Kanti Children's Hospital receives cases from all over the country, and around half of the cases are from outside the Kathmandu Valley.
4. Capacity Development of Non-Specific Health Care Providers in the Primary, Secondary, and Tertiary Level of Care in Child and Adolescent Mental Health Issues - Working Area - Province 2 - Expansion to six different municipalities
5. Training of Child Specialists working in Juvenile Justice Court: Now working in different parts of Nepal
6. School Mental Health and Life skills Program – 2 Schools in Kathmandu Valley, to be extended further in future
7. Identification and Management of COVID 19 Related CAMH Issues: Different parts of Nepal through online sessions
8. Identification and Management of COVID 19 Related Stress among health care frontline workers
9. Improvement in the mental health status of the children and adolescents attending the Kanti Child and Adolescent Psychiatry OPD from different parts of Nepal
10. Training and capacity building of doctors and para medical professionals of Province 2 for early detection, basic intervention, referral and management of Child and Adolescent Mental health related cases. Development of a referral chain locally for the management of the same, with tele-supervision from the team at Kanti CAP OPD. This will impact the children and adolescent population of Mithila Municipality, and later expand to the rest of Province 2. This training manual has been endorsed and disseminated by the Ministry of

Health, Government of Nepal. Further Trainings are planned for the year 2021-2022 under initiative of the Ministry of Health.

a) Life Skills Education (LSE): A school mental health program. The team members have been developing a curriculum for schools based on WHO Life skills, schools in the Kathmandu Valley are approached to incorporate the curriculum in their regular academic curriculum. The curriculum has been designed from primary to higher secondary level students. This has already been tried in 2 schools and plans to advocate the inclusion of Life Skills Education into the school curriculum in Nepal, which can help in promotion of CAMH as well as prevention of CAMH issues in future. Draft of the Manual on LSE is ready, and work is being done on the reference manual. However, due financial reasons it will still take the time to complete.

b) Training of Child Specialists working in Juvenile Justice Courts. This training that the team conducted in collaboration with the National Judicial Academy, enabled to empower child specialists in juvenile justice courts with the necessary perspective and skills to evaluate and manage cases of children and adolescents with the lens of child and adolescent mental health. This would greatly impact their inputs and advice to the management of such cases in the courts and would provide a CAMH perspective to the overall approach, decisions and management of such cases.

c) Training of Teachers on “Reducing Violent Disciplining in Schools”. Although physical punishments in schools have been declared punishable by law, it is still a highly prevalent issue. By development of this manual and training of teachers in different parts of Nepal in collaboration with the partner organization TPO, the team aims to have an impact on the mental health of children and adolescents in different parts of Nepal. The Manual has been developed; training has been planned but halted for now due to COVID 19 pandemic.

d) COVID 19 related CAMH Problems - Identification and Management. This is a training project that was started after the COVID 19 pandemic started and lockdown began in Nepal. This aims to provide training to mental health professionals on COVID 19 related CAMH issues. This can help to mobilize the available resources to manage the CAMH impact of the COVID 19 pandemic. Manuals have already been developed; Training of Trainers (TOT) was completed for 90 psychiatrists and psychologists, who have in turn taken sessions for children and adolescents, parents, teachers and caregivers. Have reached more than 100,000 people in total, more than half of which are children and adolescents. These sessions were conducted mostly on online platforms such as Zoom.

e) Supportive sessions for Frontline Health Workers. A manual was developed to conduct sessions for frontline health workers. Mental health professionals such as psychiatrists and psychologists were trained in these manuals and they in turn have conducted sessions in their respective hospitals, medical colleges, and health care institutions. The sessions have been conducted online as well as on a physical platform with safety measures in place. So far more than 500 sessions have been conducted with a reach of more than 1456 health care professionals in frontline for COVID 19.

f) Coordination & Cooperation. In the journey over the last few years, the unit has been receiving tremendous support from the national and international partners, who have been contributed with financial aids, expertise, and moral support to scale up the program. Funding support has been provided by Norwegian Psychiatric Association, FORUT Norway, TOUCH Ireland and UNICEF Nepal. The Kanti Children’s Hospital has provided land to construct the building dedicated to the child's mental health. Australia Nepal Mental Health Network has provided educational grants to pursue Child Psychiatry training to India. Without collaboration and cooperation, it is almost impossible.

Challenges

Even though there have been improvements in the overall child health programs and hospital services, child and adolescent mental health has not been included in any of the government plans regarding child health. Exclusion of child and adolescent mental health is not surprising when one

considers that mental health - as a whole - has not received as much attention as it needs to. The concrete plan to address the issues seem poor in the Government level itself. There seems to be a lack of awareness among policy makers and general population. The awareness about child and adolescent mental health is poor among parents, teachers, medical fraternity, local authorities, and government bodies. There is also a scarcity of human resources and availability of the services regarding accessibility and quality. Mobilizing the same human resources for the OPD, projects, outreach, and awareness programs, as well as activities with other partner organizations, can be challenging. Therefore, there is a possible need of more supporting staff for the CAP team. Lastly, there is a lack of sufficient funding to child and adolescent mental health specifically. However, this has been discussed in meetings with the government, and some budgets have been finalized by the Ministry of Health for CAMH activities for the new fiscal year.

Lessons learned

It has been possible to obtain cooperation from the different levels of government and non-government bodies, local authorities and community members through persistent efforts. The community-level training at Mithila Municipality, Jumla, Bardibas, Simara for capacity building was effective in training the health paraprofessionals and doctors on CAMH issues and has encouraged the team members to step up the training to cover more areas in the coming year. Endorsement and dissemination of the CAMH training manual by the government has been very encouraging and proves that persistent efforts can have a large impact on the child and adolescent population. The team at KCH hopes to expand the CAMH related knowledge in the population and mental health professionals through these training sessions in the future.

Coordination with schools has helped the team at KCH to understand the situation of schools and encouraged them to develop a life skills-based curriculum for schools. The need for tele-consultation services was further highlighted due to the COVID 19 pandemic. The team members were able to upgrade the telephone consultation services to online tele-video consultation services. These are now ongoing and will be a part of the CAP KCH services in the future as well. The COVID 19 pandemic was a challenge, but this was taken as an opportunity to reach out to the children and adolescents in schools. Development of the COVID-19 related CAMH manuals and sessions conducted were met with positive feedback from the schools. This has now created a platform to build on further with other activities related to CAMH in the future. Working with the National Judicial Academy has allowed the team members an opportunity to impact the lives of the children in the Juvenile detention centers as well as other children in conflict with the law. This has opened new doors for further work to safeguard the mental health of this extremely vulnerable population group. The team members have learnt that a holistic approach is needed for promotion of child and adolescent mental health, and for early detection and management of mental health issues in the young population.

The way forward

With cooperation and coordination with the working partners, concerned authorities, local bodies, schools, parents, and community, the team has hope to move forward on a positive note to improve child and adolescent mental health. The construction of the Child and Adolescent Psychiatry Hospital Building will be completed shortly, and the inpatient services will start within 2022. Training of mental health professionals and paraprofessionals will be continued. The work with schools will continue in online platforms and in person settings. The study on the mental health status of children in Juvenile detention centers across Nepal is almost completed in coordination with the Ministry of Women, Children and Senior citizens, and the National Child Rights Council, hoping to publish the results soon. The work for the promotion of CAMH, prevention of CAMH issues and Management through the OPD services, in-patient services, tele-consultation services, community outreach programs and community mental health care packages through coordination with local and central government, collaborating partners and community engagement will continue.

Concluding thoughts
Nepal has come a long way when it comes to developing its mental health services. This includes an increase in mental health professionals and scaling up in community mental health programs. However, there is still a shortage of supervision, allocation of budgets, and acknowledgment from the government. Stigma remains a major issue, as well as a lack of clinical psychologists. By keeping up the dialogue with the government and the positive efforts that have been done so far, mental health services can continue to develop.

Vietnam

Mental health services and current challenges in Vietnam
The current population of Vietnam is 97,338,583 (World Bank, 2020). In Vietnam, according to the National Mental Hospital, the prevalence of 10 common mental disorders in 2014 was 14.2%. Suicide occurred at a rate of 5.87 per 100,000 persons in 2015 (WHO, 2021). The lack of mental health services in remote areas of Vietnam leaves children and young people in need helpless. Mental health and psychosocial services are available through channels like social welfare and protection centers, mental health hospitals and school-based psychosocial units. However, according to a study conducted by UNICEF, MOLISA, and ODI, their quality, and coverage are limited, and they frequently focus on only severe mental health disorders.

Vietnam has several strengths in the field of mental health. Firstly, a legislation to protect the human rights of patients exists, as well as a mental health policy and plan. However, these need to be updated. There are also efforts to promote equity of access to mental health services. Essential psychotropic medicines are available in all hospital facilities, and the mental health sector has formal links with other relevant sectors (e.g., health, education, criminal justice, etc.). In addition, mental health providers interact with primary care staff.

There are also several weaknesses of the mental health system in Vietnam. The network of mental health facilities is not yet completed, and the mental health system provides more services in mental hospitals than in the community. In addition, despite mental health legislation to protect human rights, practical implementation of the legislation is weak. There is also a limited amount of training provided to primary care staff, and family and consumers associations do not exist. Lastly, the mental health information system does not work well. In other words, there are several factors that could be targeted to improve mental health services in Vietnam.

Scaling up mental health services in Vietnam
Department of Psychiatry in Vietnam National Children's Hospital - an example of scaling up mental health services

When I was a student in the clinical psychology of children and adolescents' program at the University of Education, Vietnam National University, Hanoi, I had the opportunity to complete a practicum at the Psychiatry Department of Vietnam National Children's Hospital. At that time, I learned about the history of the Psychiatry department's development. I have personally witnessed people's attempts to expand mental health care for children and adolescents.

From 1981 to 1993: *The Psychiatry Department was established in 1981. Due to a personnel shortage, the Department incorporates two disciplines, psychiatry, and neurology, under the Neuropsychiatric Department, which has 25 inpatient beds. The department has two child psychiatrists and one pediatric neurologist, as well as ten nurses and two aides. The Swedish Government is supporting the establishment of the Neuropsychiatry Department. In the early 1980s, Child and Adolescent Psychiatry*

was a brand-new specialization in Vietnam. However, the Board of Directors of the Vietnam National Children's Hospital recognized the importance of this department from the outset and worked diligently to build favorable conditions for its growth. To overcome the early challenges, the Department enlisted the assistance of the Board of Directors of Vietnam National Children's Hospital and the Departments of Psychiatry and Pediatrics at Hanoi Medical University in order to implement a mental health care model. The Department's primary responsibility is to provide inpatient treatment for children suffering from mental health problems such as stress-related behavioral-emotional disorders, pervasive developmental problems, epilepsy, and other mental illnesses.

Due to a lack of professional experience, the Department has encouraged its staff to self-study and actively enroll in specialist Psychiatry and Pediatrics training programs to continue to develop their professional and foreign language abilities and facilitate access to international expertise. Because there is no specialized training facility in Child and Adolescent Psychiatry, the Department has encouraged the Department's doctors to conduct research, learn, and strengthen consultations with leading experts from the Institute of Mental Health, Department of Neurology, Bach Mai Hospital, Vietnam-Germany Hospital, and others. In 1990, the Center for Child Psychology Research was founded and led by Doctor Nguyen Khac Vien. The Department cooperated with the Center to conduct further research on clinical psychology.

From 1993 to 2002: *After more than a decade of operation, in 1993, the Board of Directors decided to establish the Department of Psychiatry on the basis of the Department of Psychiatry - Vietnam - Sweden Children's Hospital (now the National Children's Hospital). Once again, the Department has embarked on the construction of a new facility, a working process appropriate for the conditions and peculiarities of the specialty, ensuring the responsibility assigned by the Hospital. The department is equipped with twenty inpatient beds, a room for testing and psychological treatment, a counseling room, a playroom, and a playground for children. The inpatient system is for patients who are far away and require active intervention. Besides the inpatient treatment system, the Department also handles outpatient care for thousands of patients suffering from epilepsy and mental disorders in all regions. The Department has constantly enlisted the assistance of the Institute of Mental Health, Department of Psychiatry, Department of Pediatrics, and Hanoi Medical University, and cooperate with N-T Center as a specialized team. The NT Center has helped the Department to re-equip lecture rooms, playrooms, as well as provide professional materials, organize training courses for medical staff at a number of facilities in Hanoi and Ho Chi Minh City on psychological approaches, as well as clinical psychology applications in Child and Adolescent Psychiatry. As a result, the staff's skills in assessment, diagnosis, therapy, counseling, and application of psychological tests are more methodical.*

From 2003 to 2011: *There were 20 employees, including four physicians, four psychologists, three instructors, eight nurses, and one contract nurse. Since 2007, when the department was established by the hospital, it has operated under a new model, with five rooms for daily inpatient treatment and four clinics for outpatient assessment and psychological testing*.

From 2012 to present: *The Department's primary responsibilities are to examine, evaluate, do psychological testing, diagnose, pharmacological treatment, and provide psychotherapy for mental health problems in children. In addition, the Department of Psychiatry also undertakes the*

implementation of psychological care for hospitalized children, interdisciplinary consultations, medical assessment, and certification of disease status, and participates in psychological counseling for hospital organ transplants. Outpatient services at the Department have increased in recent years, with an average of 80-100 people each day. Additionally, the Department engages in several media-based health education programs, demonstrating its leadership in the field of pediatric mental health treatment.

Future development directions

In Vietnam, only the National Children's Hospital has a Department of Psychiatry. The country has a dearth of pediatric psychiatrists. Children with mental health problems often go to Pediatric Hospitals and Clinics but are seldom admitted to the Pediatric Department of the Psychiatric Hospital. Children who suffer from mental illnesses may exhibit a variety of physical symptoms. Moreover, many parents have a bias of going to a "psychiatric" doctor, so they do not take their children to a mental hospital.

Through the opportunity to study, seminars at home and abroad, they realized that it is necessary to have asynchronous development of the health sector, especially the system of family doctors, social workers, and school doctors. There are new psychopathological problems detected early and timely intervention. There is a need to create a close link between education and health systems to support children with mental disorders, in order to be continuous and adequate. In professional work, there is often a close cooperation between pediatricians, psychologists, social workers, rehabilitation staff, special education supervisors and pediatric psychiatric facilities. In advanced countries, medical examination and treatment are mainly by appointment, the number of inpatient beds is not sufficient, and there is a close connection between hospitals and specialized educational institutions.

To be able to build and comprehensively develop the Department of Psychiatry - National Children's Hospital to the point where it can serve as a center for education, training, scientific research, international cooperation, diagnosis, and treatment of health issues, as well as offering the nation's premier child mental health service, there is a need to establish objectives such as the following:

a) Developing a team of highly educated personnel via continuous education, participation in seminars - thematic scientific activities in the field of psychiatry, and active acquisition of knowledge from domestic and international experts

b) Connecting and establishing a network of autism and other developmental problem activities between the National Children's Hospital, local hospitals, and intervention centers throughout the North. The Department of Psychiatry, in particular, is a trustworthy institution, contributing significantly to autistic children and their families' access to essential and appropriate therapy.

c) Collaborate with both domestic and international universities (Medical universities, psychology training institutions, international students, volunteers etc.). Developing a specialist pediatric psychiatric training program in conjunction with the Doctor of Pediatrics.

d) Developing and establishing psychiatric services in pediatric and obstetric hospitals in the North and Central provinces

e) Resources: Combined with the National Children's Hospital's general development initiatives; local hospitals; and support from domestic and international organizations.

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Information has also been acquired through interviews with the senior psychiatrist at KCH, working experience as a part of CAP, and through meetings with TPO Nepal.

CHAPTER 7

COMMUNITY BASED MHPSS *INTERVENTIONS* IN EMERGENCIES

By Monalisha Pradhan, Paula Marie Olsen & Kajsa Sagnes Matthaus

Background

"A serious, unexpected and often dangerous situation requiring an immediate action" is termed as emergencies. Any kind of disastrous situation or emergencies can have significant psychological and social stress on individuals, families and communities. People who face such disaster may have affect in their living conditions significantly even after they have reached to safety. Men and women, and boys and girls of different ages, may have different ways of experiencing and expressing distress. Their reactions to disruptive situations are often overcome with time however, it depends on their coping mechanism. Some who cope with difficult experiences may become more resilient if a supportive family and community environment is available. Some people are more vulnerable to distress, however, especially those who have lost, or been separated from, family members, or who are survivors of violence and takes time to overcome despite of adequate support. In an attempt to help those survivors, victims and traumatic people concept of MHPSS was emerged all around the world at large including Nepal.

Nepal is a landlocked country occupying an area about 1,47,181 sq.km with different geographical region. The current population of Nepal is **29,886,126** as of Wednesday, December 8, 2021, based on World meter. Nepal is rich in its own culture tradition, custom and language. Due to the variation in geographical condition and other aspect, many natural disasters like landslides, flood, earthquake keeps coming to Nepal when many Nepalese people must suffer from crisis and undergo with poor mental and physical condition. Compared to physical treatment, mental health treatment is still lacking for which day to day awareness and concept of psychosocial intervention are announced with the help if NGOs, INGOs and Ministry of Health.

However, after the devastating earthquake on April 25, 2015, mental health needs in Nepal increased considerably. The alarming rate of suicidal ideas in 10 percent of earthquake-affected populations revealed through a rapid survey indicated the high mental health burden. As there is no mental health desk at the Government of Nepal's Ministry of Health (MoH), the UN World Health Organization (WHO), as co-lead of the Health Cluster, is supporting the MoH to fill this gap. Immediately after the 2015 earthquake, there was an urgent need to coordinate among partners implementing mental health response activities to ensure adherence to WHO and Inter Agency Standing Committee (IASC) guidelines.

Disaster event

Introduction

Mental Health Psychosocial Support in general
Psychosocial support refers to actions that provides immediate relief suffering, both emotional and physical, improve people's short-term functioning and reduce long-term negative psychological effects. (Source: IRFC Psychosocial Framework). The term 'mental health and psychosocial support' (MHPSS) refers to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. MHPSS interventions can be implemented in programmed for health & nutrition, protection (community-based protection, child protection and SGBV) or education. The term 'MHPSS problems may cover a wide range of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities.

Mental Health Psychosocial Support in Nepal
MHPSS in Nepal is integrated to primary health care centers, tertiary level hospitals, early childhood development school programs, by training and supervision.

Mental health and psychosocial interventions are also provided in the form of psychotropic medication, basic emotional support, focused psychosocial counselling and detection and referral services to those affected by disasters like the earthquake and with pre-existing mental health problems

Improving the access to services and support seeking behavior of mental health patients by increasing community awareness about mental health issues and decreasing stigma.

Purpose of providing Psychosocial Services

Hobfoll et al. (2007)

Providing early and adequate MHPSS can prevent distress and suffering from developing into something more severe. It is crucial to provide earlier mental and psychosocial in disaster and trauma relief to help individuals, families, and communities deal with distress, suffering, and sorrow and to ultimately recover.

Community based MHPSS in Nepal

A number of interventions can be labelled as community based MHPSS provided, they are part of a more strategic psychosocial and mental health approach with the aim to build on existing individual and community resources, capacities and resilience. A community based MHPSS approach in Nepal aims:

To Strengthens natural supports and systems.

Makes use of community knowledge and capacities.

Requires skills and a thorough analysis of local practices and resources to carry out MHPSS. programs in line with the principle of 'do no harm'.

Involves community engagement in all phases of programming.

Layers of the IASC MHPSS Pyramid

Different strategy and MHPSS intervention are used in communities during Emergencies

- Peer support.
- Cultural and recreational activities for children.
- Identification of vulnerable families for referral to specialized supports.
- Psychological first aid (PFA).

Psychological First Aids (PFA)

Three basic action principles of PFA (Slide 29)

Look	• Check for safety. • Check for people with obvious urgent basic needs. • Check for people with serious distress reactions.
Listen	• Approach people who may need support. • Ask about people's needs and concerns. • Listen to people and help them to feel calm.
Link	• Help people address basic needs and access services. • Help people cope with problems. • Give information. • Connect people with loved ones and social support.

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Community PHPSS intervention used in group, peer support, individual setting

During emergencies in Nepal, different social programs were organized to create a sense of self, security, protection, hope and togetherness. Individual counselling sessions in primary care centers were provided. Similarly, many different programs like street drama, dance therapy, tension release exercises, in group settings were also provided in the communities. Apart from that, gender base discrimination and discrimination between the case were tried to eliminate in the communities by drama and awareness program. This would not only help to create mental stability but also would help to make it comfortable to work in a group.

Some institutions involved in Nepal for MHPSS during Emergencies:

- CMC NEPAL
- TPO Nepal
- KOSHISH Nepal
- CWIN

Child and adolescent mental health: Covid-19 pandemic in Nepal

The covid-19 pandemic is an ongoing crisis all over the world. Since the beginning of 2020 it has had an impact on people's everyday life and for some life will never be the same as before the pandemic. According to The Kathmandu Post, the first nationwide lockdown in Nepal began on the 24th of March 2020, after two reported cases of coronavirus in the country. This prohibited all public movement outside the home, except necessary movement to buy groceries, and movement of all vehicles, except for those belonging to essential health workers or security forces (Pradhan, 2020). Based on what locals from Nepal have told me, the first lockdown came suddenly and unexpectedly on many people. Schools closed, people had to work from home and could not perform their daily activities and chores as they were used to. A restricted everyday life with concerns about the virus and its possible consequences, both for oneself and their loved ones. This led to increased stress in this new and unfamiliar situation.

During my stay in Nepal, I spent two weeks at the Child and Adolescent Psychiatry Unit at Kanti Children's Hospital. During this time, I got more information about the covid-19 situations impact on children and adolescents, and Kanti's work to promote mental health in children and adolescents all over Nepal in general, both before and during the ongoing pandemic. Based on my observations at Kanti, interviews with the staff and reading of the manuals, I have decided to focus this part on the Child and Adolescent Mental Health training modules (made before the pandemic) and the Covid-19 related stress manuals.

Child and Adolescent Mental Health (CAMH) training modules

In Nepal there are very few psychologists and psychiatrists, and the awareness of mental health is limited. Through work with focus groups, the psychiatrists and psychologists at Kanti saw that a lot of symptoms of mental health issues were misunderstood or missed out by doctors, nurses and other health workers. In discussions within focus groups consisting of doctors, parents, teachers, health workers and voluntary women the participants first said that they did not observe any symptoms of mental health issues. But after deeper conversations and discussions, it came clearer that symptoms observed through their work could be symptoms of mental health problems. Problems with mental health were presented as both somatic and behavioral symptoms among various patients. This link was something not all involved workers knew about. By making people aware of this connection, it also makes it easier to understand how one may identify and approach these issues to manage them. They also discussed substance abuse, as a sign of mental health problems, and how it may be used as a way of coping and self-medication. After seeing this misunderstanding and ignorance towards mental health issues, the psychologists, and psychiatrists at Kanti saw the need to educate and evoke health personnel about these problems and how to deal with them. They developed Child and Adolescent Mental Health training modules as handbooks. There is one facilitators guide, one reference manual and two participant handbooks - one for medical doctors and one for nurses and paramedics. The participant handbooks are made for the personnel who will participate in the five-day Child and Adolescent Mental Health training. They provide basic knowledge and guidance to manage

mental health issues in a non-specialized setting, and information about where and when to refer to specialists if necessary.

The handbooks are made to give other health workers information about mental health and how to promote mental health in children and adolescents. They are made in collaboration with the Department of Health Services, and it is aligned with the WHO mhGAP 2.0. The training is provided by a combination of clinical psychologists and psychiatrists. In this way the health workers should get tools to provide adequate help to parents and children who suffer from mental health problems. As mentioned, mental health issues were often misunderstood by other health workers. After teaching in these handbooks more health workers should be aware of mental health and how psychological issues may show as physical or behavioral symptoms.

This is a way of task shifting by including more health professions so they may contribute to promoting mental health as well in cooperation with the mental health professionals. In Nepal there are few clinical psychologists and psychiatrists, which makes the task sharing extremely important in order to cover the psychological needs of the population. This is also a way to reach out to people living in more rural provinces where the access to mental health professionals is often insufficient. People often must travel far in order to get help from mental health professionals, which may contribute to people not seeking help at all. In addition to this the lack of knowledge about mental health issues and low awareness of possible treatment may also reduce the amount of people seeking help. After educating health workers in both urban and rural provinces of Nepal, they should be able to provide psychosocial support to children and parents. They should also know which cases they may help locally and when they need to refer to mental health professionals for further investigation and treatment. The handbooks are approved by the government and may be used all over Nepal.

Covid-19 related stress and stress management

When the Covid-19 pandemic hit the country in March 2020 the clinical psychologists and psychiatrists at Kanti saw a further need to promote mental health and psychosocial support among children and adolescents. The schools closed suddenly, and the school system was not prepared for transition to digital learning methods and lessons. It took about 1-2 months before online classes started, and in the most rural provinces the opportunity to attend digital classes was poor, and some children and adolescents did not have the opportunity to participate. Other children struggled with this type of class as well. It changed their routine and children who had parents working in the health sector had to stay at home by themselves and manage the digital challenges alone. One psychologist told me that even small children could be left home by themselves because their parents had to work. This psychologist had spoken to a five-year-old who had been scared and sad because he/she was left home alone while the parents worked. It was also challenging for teachers who had limited experience and capacity to create and perform digital classes. This was also challenging for parents who had to work from home while helping their children with digital classes or dealing with the child's non-attentive and possibly disturbing behavior. This affected their routines in a significant way. In addition, many children and adolescents were exposed to news about the pandemic worldwide and got frightened by the images and stories about the virus. This made them scared and stressed about their own and their loved one’s health.

During and after this first period the staff at Kanti saw that few people came to seek help physically, but the number of calls increased. There was an increasing level of stress related symptoms among teachers, parents and children/adolescents. They saw a need to conduct sessions with schools, and this had a useful effect. Two manuals about this specific type of stress were made by the Child and Psychiatry Unit at Kanti and CWIN Nepal, supported by UNICEF Nepal: Identification and Management of Covid-19 related stress in Children and Adolescents - one manual for sessions with parents, teachers, and caregivers, and one manual for sessions with Children and Adolescents. They

came in touch with schools and conducted interactive sessions about how to recognize stress and how to help others who experience stress. The sessions were short due to a lack of time and patience during these circumstances. In the beginning the sessions were conducted digitally because of the Covid-situation, but after some time physical sessions were also conducted in a manner that secured infection control. For instance, some sessions were conducted outside. Conducting sessions digitally was also a method of reaching out to urban areas outside of Kathmandu. A challenge with this may be the coverage and access to digital aids. According to the psychiatrist at Kanti the network and access to digital aids should be relatively good in these areas - he says that “There are more phones than people in Nepal. Nevertheless, the internet connection is often unstable which may make it challenging to perform sessions online in these areas, in addition to the fact that there may be a lack of suitable equipment. In the more remote areas, few online sessions were held, due to limited network coverage.

By this method they reached out to approximately 40.000 people - 20.000 children and adolescents and 20.000 adults online during the first wave of covid, according to the psychiatrist at Kanti. When the second wave of covid hit the country, it hit even harder and led to more hospitalized people and deaths. This led to an increased focus on loss, grief and trauma. In some areas, almost entire families were hospitalized. They wanted to reach out to people in all provinces, and therefore trained people using these manuals. The training was again conducted both digitally and physical, with precautions to avoid the spread of Covid-19. In this manner they reached out to about 40.000 children and adolescents and 20.000 adults. In total, they have reached out to more than 100.000 people with these sessions.

There have been several disasters in the past, and there will be more in the years to come. Therefore, it is important to be prepared to manage crisis situations. In these modules Covid-19 is the stress factor, but it may be replaced with other variables in later emergencies, like floods or earthquakes. This makes the handbooks and the covid-manuals a good example of what we have discussed and studied this semester - for instance task shifting, the making and using of modules that are adjustable to context, and how to use the steps in the intervention pyramid in a suitable and efficient manner.

To sum up

Kanti’s contribution to the field of mental health in children and adolescents in Nepal is pioneering and inspiring in this context. The CAMH training modules and the modules about Identification and Management of Covid-19 related stress in Children and Adolescents are good examples of task shifting and efficient use of the steps in the intervention pyramid, which are strongly needed in this context where psychologists and psychiatrists are few in number.

Thank you to the staff at the Child and Adolescent Psychiatry Unit at Kanti Children’s Hospital for the interviews.

Females in emergency in Nepal: Two community-based organizations

Introduction

This part will focus on females in emergencies in Nepal. We will present this theme through two community-based organizations that we have visited in person.

The reason why we focus on females in this part is that females are especially vulnerable to emergencies. This is true for females throughout the whole world. During emergencies like armed conflict or natural disaster women and children are particularly vulnerable. When it comes to being a refugee and displaced because of war, natural disaster, persecution and famine, women and children take up 75 percent. Many women are already vulnerable and poor before fleeing. When women are taken away from their partners and communities, potentially alone with their children, they are even more vulnerable to sexual exploitation and violence. Natural disasters are an increasing factor to emergencies, which is worsened in combination with poverty and environmental destruction

(UNFPA, 2021). This is relevant to Nepal, which is a county who has experienced natural disasters like major earthquakes and floods.

We will also focus on girls throughout this part of the chapter. Girls are especially at risk when a disaster happens. Girls face gender inequality and discrimination on a daily basis. This includes girls being more likely to drop out of school, being victims of violence, marry at a young age, becoming pregnant and losing income. All this hinders girls throughout the world of developing and reaching their potential (Plan International). This part will take you through examples of organizations who work with girls and women who face emergencies.

CWIN: Helpline office in Kathmandu

What is CWIN?

The first organization we are going to present is CWIN, which stands for Child Workers in Nepal Concerned Center (CWIN). At CWIN they work for children's rights and mental health. CWIN was established in 1987. They pioneered working with children’s mental health, child exploitation and abuse in Nepal. CWIN has an office in Kathmandu where they receive calls on their helpline. Everyone in Nepal can call this helpline and report about children they know is in an emergency. If the emergency is severe enough CWIN cooperates with the local police on emergency rescues to get the children. The children are brought to the office in Kathmandu and if there is further need for longtime support the children are sent to a peace home. CWIN has two peace homes, one for boys and one for girls, outside of Kathmandu.

The 5th of November 2021 we visited CWIN helpline office in Kathmandu. We learned about CWIN’s work and got a tour in their building.

The staff
First, we sat down with a woman called Pooja, who works for CWIN. She introduced us to CWIN and showed us two information videos about CWIN. At the office we also met several other staff. One main person was a woman. She was sort of a “superwoman” at the office. She gives the children counseling; she participates in court cases, and she participates in emergency rescues. According to Pooja, it is because of people like her that they can run CWIN and that the children are taken care of. The woman had not gone through academic education in the field of mental health and psychosocial support, but she had gone through a 6 month course on the topic. She had also gained a lot of experience from working closely with the children.

Other staff included a lawyer who took care of the legal issues concerning children, a diver that picks up children in emergency rescues, a caretaker who takes care of the children on a daily basis, interns from college and workers who respond to the calls on the helpline. When visiting the building we got to see the room where staff responds to emergency calls. When we visited, there were two women working there. They had their own desk, a telephone, and some notes in front of them. We asked them some questions about their work. They said that it was hard work, responding to emergency calls and listening to the traumatic stories children face. They also told us stories where the children got help from them and recovered from their trauma.

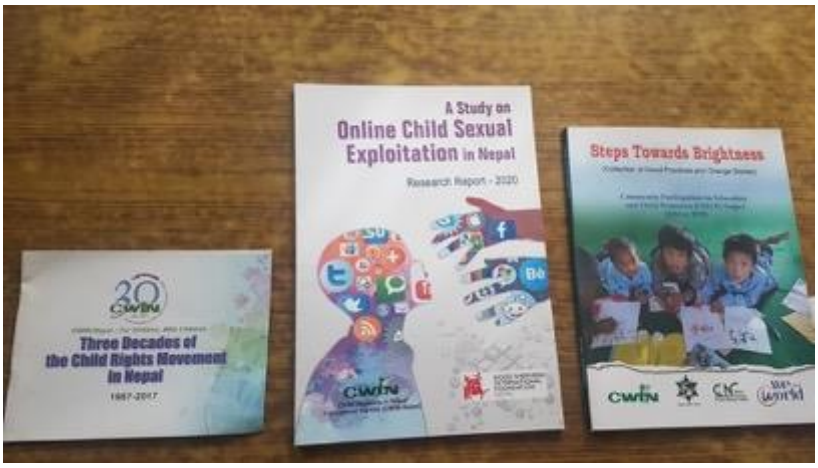
Gender differences, education and counseling
We asked about the typical emergencies that children face and the gender differences. It is mostly girls who are reported about in the emergency calls to their helpline. The emergencies girls face are domestic violence, sexual abuse and corporal punishment. The boys who get help from them are usually homeless, orphans and exploited for work. In severe cases the children are first reduced by CWIN in cooperation with local police and brought to the office in Kathmandu. After assessment they may be given counseling and education at the office, or they will be sent to the peace homes.

At the office in Kathmandu and the peace homes the children get their basic rights covered. They get food, shelter, medicine, counseling, and education. The education consists of regular school, dance and music classes and classes in different handicrafts. This helps the children recover from the hardship they may have experienced; the children thrive and develop and feel safe and taken care of. Education is also very important so that the children can continue into higher education later and get work to survive when they get older.

This picture is from the counseling room inside the office. Here the children receive counseling from staff at CWIN and twice a month a professional psychologist from Kanti comes. Kanti is the only children's hospital in Nepal, located in Kathmandu.

Advocacy

At CWIN helpline office we learned about one of the core functions of CWIN, which is creating a social movement with the focus on the child's mental health and rights throughout Nepal. CWIN advocates this throughout different mediums and tries to reach as many people as possible in the whole of Nepal. They advocate at schools and create manuals and brochures for adults working with children and parents on how to take care of the child's mental health and rights. Here is a picture of some of them.



Another important way to advocate and inform is through their rememberable sticker that they put up wherever possible. The sticker informs about their helpline number (10-9-8) and that it is an emergency number that anyone can call.

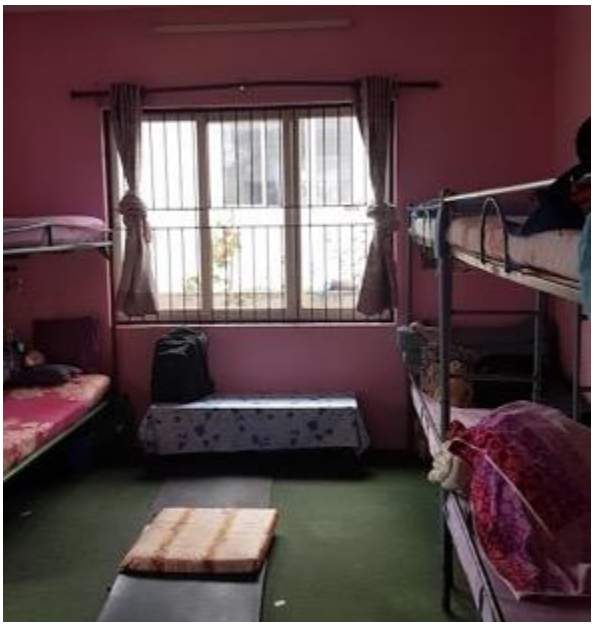
CWIN: Peace home outside of Kathmandu

On the fourth to the fifth of November 2021, we visited CWIN Balika Peace home outside of Katmandu. Right now, thirty girls are living at the Peace home. Their ages range from four to eighteen years old. At the peace home they are taken care of by staff who are trained in mental health and psychosocial support.

The girls
We got to meet the girls at the Peace home and spend almost a whole day with them. After a short information meeting with two of the staff at the Peace home we got to meet the girls. In the beginning some of them started to approach us. We sat together outside one of the buildings and introduced ourselves to them and vice versa. After a while more girls started to join and almost all the girls gathered to take us along on a tour of the area.

The Peace home consists of four different buildings with different purposes. The largest one was devoted to recreation, education and eating. Here is a picture of it.

The other one was a dormitory where the girls lived four together in a room. As they guided our group along, some of the girls held our hand. They showed us their rooms and garden, which they had made themselves. Over their beds, many of them had drawings and pictures and some had dreamcatchers. On the walls they also had homemade art.



After the tour, we all went back to the recreation room where the girls put on music, and we all danced together. We danced and talked for several hours. It was a wonderful experience.

The staff

We met with two of the staff at the Peace home and got to ask them some questions. They told us that working at the Peace home was both challenging and inspiring. Some work there twenty-four hours a day. They play with the girls, educate them in different fields, make food for them and have counseling sessions with them. During the covid-19 pandemic it was especially hard, because the home was closed off from the rest of society and the girls did not go to school. The staff said that they did not see their own family for several months.

After talking to them and visiting the helpline office, I wondered how they themselves were taken care of. It can be very difficult to work with children in emergencies and listen to their traumatic stories. I asked Pooja what they did at CWIN to take care of their staff. She answered that the staff learn about self-help, they can take 2 weeks leave, they are offered a retreat and they have constant training. She said that the staff is still burned out and carry with them the difficult stories of the children. It would be better if they had more resources to ensure the health of the staff more. Thankfully, they still have a lot of courage and manage to continue their work despite it being very hard.

Picture from the office room at the Peace Home.

KOSHISH

The second organization is called KOSHISH and was established in 2008. They describe KOSHISH on their website as National Health Self-Help Organization/Organization of Persons with Disability. They strive for mental health and psychosocial support to be more included in the health system and in general in Nepal. KOSHISH works for the rights of persons with disabilities, mental health conditions and psychosocial disabilities to be upheld.

The way they work is by having a person-centered right based approach in their community services (KOSHISH, 2021).

KOSHISH works for CRPD to be followed. CRPD stand for Convention of the Rights of Persons with Disabilities and is one of the conventions by the United Nations. The convention is targeting human rights and fundamental freedoms for humans with disabilities. This convention forms, together with other documents, an international guideline for national policymaking and legislation. This involves nations cooperating in building inclusive societies and promoting disability inclusive development (United Nations). With this information one can say that KOSHISH has community-based services, but it also strives for changes and rights to be upheld at a higher level (governmental level). KOSHISH states themselves that their mission is to “ensure a dignified life for persons with mental health conditions and psychosocial disability” (KOSHISH, 2021). This can only happen if basic human rights are in place.

This picture is of Matrika Devokota, the founder, holding a sign about CRPD taken from their website (KOSHIS, 2021).

KOSHISH: Female transit home

The twenty first of November 2021, we visited the KOSHISH Female Transit Home. This is a home where they take in women that they rescue from difficult situations. These women may be victims of human trafficking, prostitution, homelessness and/or have mental health conditions. When we visited the home, we met Matrika and a woman. She told her story about her life and how she ended up at this transit home.

We will give you a description of her story based on our conversation. She was sold by her stepfather as a child to human trafficking. She was then sent to India where she was forced into prostitution. She worked at a brothel, which she was later able to escape from. She fled back to Nepal. Unfortunately, she was convicted of possession of drugs that were not hers and she ended up in prison for several years. After being let out of prison she ended up living on the streets.

It was from here that she was rescued by KOSHIS. She was taken to the female transit home. She told us that when she first arrived, all she wanted was to eat and she begged for food. Before she was given any food, she was demanded to get a shower and some clean clothes. She made some resistance to this offer, but she was later convinced. In the beginning she was very angry, and she did not trust anyone. With the help of the women working at the female home she later recovered. Here she got support, security and was met with empathy. She said herself “KOSHISH changes lives.”.

Taking part in this conversation and listening to her story was very moving. This seems like an extreme life-story, filled with horrible and traumatic events. I remember thinking, how could this woman still stand on her feet after experiencing all this, and how could she ever trust another human again? Her story and what she said, showed that even after all her adverse experiences she had recovered, restored faith in other humans and she could now live a more normal life. After recovering herself she was offered to work at the transit home to which she accepted.

I asked if the females working at the home got any training. Marika answered that the workers got training in basic psychosocial support. He also stressed that the most healing thing to be met with after experiencing trauma is empathy and compassion. He told us that all humans have these capacities, to be empathetic towards others, and that we should meet people in our lives this way. Instead of taking advantage of women in vulnerable situations, this home welcomes them with empathy and support. Matrika said that these women are not dangerous to anybody, they just need to be taken care of and supported.

Another question that came up during the conversation was the funding of KOSHISH. I asked Martika if he wanted more funding from the Nepalese government. His answer was no. His reasoning behind this was that if the government funds it, they also want to run it. This would mean that the government decided how it should be run, or they would send a lot of women with mental health conditions to him. He said that KOSHISH cannot help everybody in difficult life situations. He wanted to continue ensuring a safe home and worthy life for the women who are taken into KOSHISH. Working with humans and mental health conditions is about support during the whole lifespan according to Matrika.

The reason why this is an example of community-based work and mental health and psychosocial support in emergencies is because of how KOSHISH work. Their female transit home is located in the center of Katmandu. This center takes in women that they find on the streets, that have been in contact with the health system or that they know are in difficult life situations. KOSHISH goes out on searches for these women to bring back to the transit home. This means that KOSHIS is in direct contact with the community both in Kathmandu and rural areas. They focus on helping people with mental health conditions and disabilities. A concrete example of mental health and psychosocial support is the female transit home, where their staff is given education and practical experience when being in contact with the women.

Conclusion

Even though females are especially vulnerable to different emergencies these two organizations show us that females are helped tough out Nepal. Females who face different emergencies are met with care and support in contact with CWIN and KOSHISH. These organizations show an engagement in helping females and upholding their basic human rights. They view females as resources to society, who can contribute with their empowerment, they can thrive and recover. Because of these community-based organizations, they are able to reach females in emergencies throughout Nepal.

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PART 2

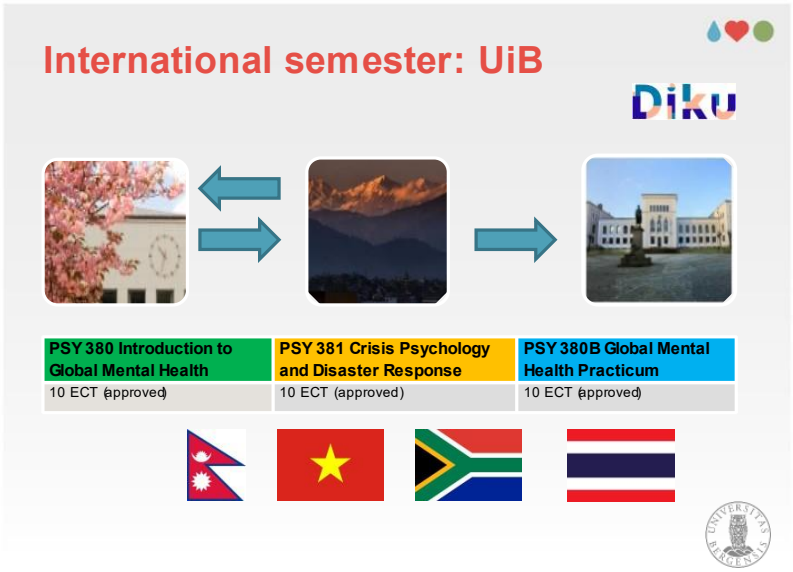
CHAPTER 8

ORGANIZING AND ADMINISTRATING INTERNATIONAL SEMESTER AND INTERNATIONAL CO-OPERATION IN HIGHER EDUCATION

By Gøril Vikøren Nøkleby & Jarle Eid

The «International semester" in global mental health is an elective (30 ECTS credits) semester for students attending the clinical psychology program at the University of Bergen. Each year a group of about 20 Norwegian and international students are admitted to this program at the Centre for Crisis Psychology (CCP).

CCP is an independent center at the University of Bergen, Norway. From early on the center had an ambition to reach out and establish international collaboration on research and education. Through fundings from DIKU (now; HK Dir) the center acquired funds to support three student outreach opportunities in psychology and global mental health. From 2019 the CCP has been a Norwegian partner in two NORPART programs. In the first NORPART program we are collaborating with the University of Oslo and with Tribuvan University in Nepal as the international partner. In the second NORPART program we are collaborating with Inland Norway University of Applied Sciences and with Vietnam National University as the international partner. In addition to this CCP is the lead institution from Norway in the INTERN ABROAD program at HK-Dir, with the Field Band Foundation in South Africa as our international partner. Finally, we have established the agreements needed to send students from Norway to the Asian Disaster Preparedness Center (ADPC) in Bangkok, Thailand. In the following we will give a brief outline of the four international partner projects.



NORPART - Nepal

The overall aim for this project is to enhance the quality of education of mental health professionals in Nepal and Norway through academic cooperation between the Universities of Oslo, Tromsø and Bergen in Norway and the Tribhuvan University in Nepal. In addition

to the main partnering universities selected NGOs and partnering institutions such as Oslo University Hospital (OUH), Norwegian Psychiatric Association (NPA) in Norway and Psychiatric Association of Nepal (PAN) will contribute to fulfill the following main goals of the program: (A) To strengthen partnerships for education and research in mental health between TU in Nepal and UiO/UiB/UiT in Norway. The project will support revision of curriculum in psychiatry and clinical psychology in Nepal. In addition, the project will facilitate staff mobility between Nepal and Norway by creating opportunities for visiting scholars, working group meetings on research and education. During the project period, IOM, TU will be able to start its own PhD program in mental health in Nepal with assistant from Norwegian partners. (B) To increase the quality and internationalization of the educational programs in mental health between TU in Nepal and UiO/UiB in Norway. The project will offer new opportunities to take part in joint education and training sessions focusing on clinical, cultural, and cross-national aspects in prevention and treatment of mental health in Nepal and Norway. In addition, this project will provide an opportunity to develop joint research initiatives with implications for clinical practice in Nepal and Norway. (C) To increase mobility of master and PhD mental health students from Nepal to Norway, including mobility in connection with work placements. The program will provide travel grants and facilitate annual mobility of graduate student (PhD and MPhil) mobility from Nepal to Norway in psychiatry (UiO) and psychology (UiB), child and adolescent psychiatry (UiT). The program will provide travel grants and facilitate annual mobility of graduate student (PhD and cand psychol/cand. Med/master students in international health) mobility from Norway to Nepal, in psychiatry/medicine (UiO), psychology (UiB) and child and adolescent psychiatry. Work placements and practicum experiences will be provided by TU and the Kanti Children's Hospital in Kathmandu when the project is finalized.

NORPART – Vietnam

Inland Norway University of Applied Sciences (INN Univ.) and Vietnam National University, University of Education (VNU- UED) intend to build a partnership to enhance both institutions' capacities in higher education and research the fields of Adverse Childhood Experiences (ACE), health, and sustainable development. The main objectives are: 1. Strengthen institutional capacity at BA, MA, and Ph.D. level at both universities in the field of ACE, trauma, health protection and intervention by developing joint courses, exchange of students and staff and co-supervision of research projects. 2. Integrate cross cultural understandings and approaches into MA and Ph.D. course curricula and professional training through winter school. 3. Create digital learning resources to enhance democratization of knowledge and learning and give access to the program to non-mobile students 4. Increase number of mobile students at BA, MA, and Ph.D. level from Vietnam to Norway and Norway to Vietnam by offering Norwegian students the opportunity to do practicum and fieldwork in Vietnam, and to do courses at VNU-UED; and by offering Vietnamese students to do courses and make use of research facilities and assistance at INN Univ. 5. Increase the flow of faculty between two countries by co-teaching, guest lecturing at three institutions (VNU-UED, INN, Univ. of Bergen) at MA and Ph.D. level and professional training. 6. Increase research capacity in ACEs, trauma, and child mental health protection and intervention. 7. Raise political and public awareness of the impact of trauma and relational adversities on child and family mental health, as well as its impact on educational achievement, public health, communities, and workforce through organizing conferences and networking building with local and international NGOs and governmental agencies.

INTERN ABROAD – South Africa.

The project is a collaboration between Center for Crisis Psychology at UiB and Field Band Foundation in South Africa. The goal of the project is to create an engaging and extraordinary international semester for students at The University of Bergen with internships to the NPC (Non-Profit Company) Field Band Foundation (FBF) of South Africa. The project will support FBF in developing their internal

institutional structures and staff support, as well as give our students the opportunity to experience their education in a more holistic approach with focus on mental health in a completely different culturally diverse and economic setting. Centre for Crisis Psychology (CCP) is a national center for research, education, innovation and dissemination within emergency preparedness, bereavement, trauma, and crisis management. We have created an innovative and flexible international semester which give the students at The Faculty of Psychology structures and models to go abroad for credit-yielding internships, inspired by the U.N sustainable development goals. The main activity in the project is to test out the model created (described below) and further investigate if this model can be applied at other study programs as well e.g. Music Therapy and medicine. FBF was established in 1997 to promote, establish and develop educational community-based field bands in disadvantaged areas of the SA. FBF is a NGO with 46 bands in 23 locations in SA, with main office in Johannesburg. FBF aim to improve the quality of life of disadvantaged young people and give them an opportunity to build a better future through music and development of organizational skills. FBF has since 2001 collaborated with Norwegian Band Federation (Norges Musikkorps Forbund). This collaboration consists of mutual exchange between Norwegian and South Africa young professionals staying for 12 months in Norway and South Africa within the frames of Norwegian Band Federation and Field band Foundation, funded by NOREC.

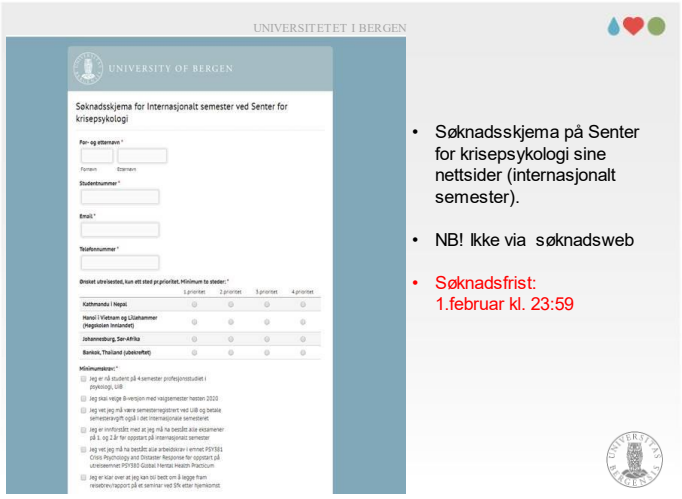
The Asian Disaster Preparedness Center (ADPC).
Asian Disaster Preparedness Center (ADPC) is an autonomous international organization that works to build the resilience of people and institutions to disasters and climate change impacts in Asia and the Pacific. Established in 1986, it provides comprehensive technical services to countries in the region across social and physical sciences to support sustainable solutions for risk reduction and climate resilience. ADPC supports countries and communities in Asia and the Pacific in building their DRR systems, institutional mechanisms, and capacities to become resilient to numerous hazards, such as floods, landslides, earthquake, cyclones, droughts, etc.

Working across a broad range of specialist areas, ADPC develops and implements cross-sectoral projects/programs on the strategic themes of risk governance, urban resilience, climate resilience, health risk management, preparedness for response and resilient recovery. Our strategic themes are complemented and underpinned by the cross-cutting themes of gender and diversity, regional and transboundary cooperation as well as poverty and livelihoods. The ADPC Academy designs and delivers specialist capacity-building and training courses at all levels and enhances the capabilities of national training centers on DRR.

Through its work, ADPC supports the implementation of the Sendai Framework for Disaster Risk Reduction 2015–2030, the Sustainable Development Goals (SDGs), the New Urban Agenda, the United Nations Framework Convention on Climate Change, the agenda defined at the World Humanitarian Summit in 2016, and other relevant international frameworks.

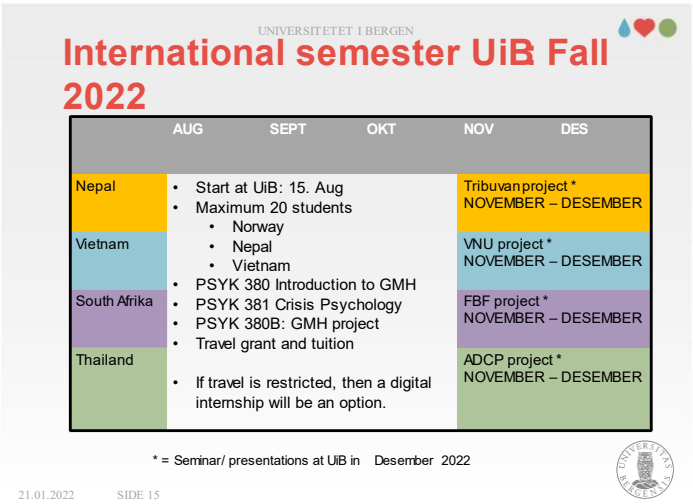
ADPC is governed by its nine founding member countries: Bangladesh, Cambodia, China, India, Nepal, Pakistan, the Philippines, Sri Lanka, and Thailand. The Bangkok headquarters and country offices in Myanmar, Bangladesh, and Sri Lanka host experts who work towards inclusive development goals across our strategic as well as cross-cutting themes.

STUDENT RECRUITMENT AND ORGANIZATION



The “international semester” takes part at the University of Bergen every fall semester, beginning in mid-August and ending in December. The recruitment of students takes place in February and students will apply with their CV and a motivational letter. The study program requires a full-time commitment and is designed to take place on cite in Bergen, although the program has in part been organized with digital seminars during the pandemic in 2020-2021. Entrance to the program requires a background in psychology or health sciences.

The study program has three modules, each with a workload of 10 ECT. The first module PSYK 380 is designed to give the students an introduction to global mental health. The next module PSYK 381 is designed to introduce the students to intervention methods and approaches to Crisis Psychology. In the final module PSYK 380B, the students will travel to one of the international sites and conduct a field visit and write a report on their experiences and accomplishments. Tuition and travel for the incoming or outgoing students are supported by grants from HK-Dir and UiB/CCP. In 2020 the program had to be 100% digital due to Covid-19 travel restrictions, but in 2021 we were able to welcome a group of students from Vietnam (VNU) and we were able to send a group of students from Norway to Nepal to do their fieldwork. In 2022 we plan to send students to all four collaborating partners ,as well as having students from Nepal and Vietnam staying in Bergen for the two first courses and the semester is planned accordingly.



CHAPTER 9

PEDAGOGICAL APPROACH AND TEACHING METHODS

By Unni Heltne & Ragnhild Dybdahl

It was clear from the preparation of the semester that both lectures and exercises had to focus on student interaction. The pedagogical focus was on making a truly global course with an applied focus. The topics were global, as was required and recommended readings. The students and teachers were international. We were extremely lucky to have excellent lecturers from around the world, thanks to zoom. The readings and lectures were chosen based on quality and relevance. The practical and applied focus was reflected in the many examples and experiences that were shared, as well as practical tasks for students, and emphasis on co-operation and communication.

Besides the formal objectives of the course, the aim was also to facilitate students' interaction and cooperation and giving the students experiences in team interaction with colleagues from different countries, with different experiences and different cultural background. Given the special context we had to focus on how to foster interaction and cooperation in a situation where they could not meet physically. In addition, there were several other challenges like different levels of studies and different degree of practical and clinical experiences, different time zones, local celebrations and national festivals and technical challenges like unpredictable internet quality.

Digital platform
We used the university equipment for teaching, and Canvas was our main communication platform. In addition to this, the students chose other platforms in their interaction like Zoom, WhatsApp and others. Canvas was a workbook where we shared background information, literature, links to interesting talks, relevant webinars and YouTube film, newspaper discussions and many other resources. Canvas was also where we shared the lecture presentations, individual and group tasks, homework and questions for group work and discussion. This way, Canvas became a source of many resources.

Preparations
Before the first lecture the students were asked to fulfil the following task:

We ask that you take a few minutes to reflect on what you understand by the terms "global" and "mental health", and suggest you write down key Words or questions that come to mind.

Similarly, we ask you to reflect on you motivation for taking part in this course.

Why are you interested in global mental health?

What are your main interests?

What do you know already?

What are your goals for this course?

How do you think that you may best contribute?

What do you hope to get out of it?

In the first lecture the students were divided into groups and asked to review their answers to each other. This became a way to get to know each other and served as a presentation. It was our experience that this task facilitated further communication between the students. Group work and discussions took place every week. Often with presentations prepared by the students based on the contexts in which they work or live, or based on research or required reading. Zoom was invaluable for dividing the students into groups, and the groups varied, so that all students got to work with everyone.

Schedule

Monday	Lecture
Tuesday	Lecture
Wednesday	Group tasks, individual task and/ role play in groups
Thursday	Lecture
Friday	Group tasks, individual tasks and/or role plays in groups

The group tasks and individual tasks were designed to stimulate discussions and sharing of experiences. In both lectures and tasks there was a focus on dialogue and participation, and the lectures used films, demonstrations, and real-life tasks. Some of the lectures were given by guest lecturers by zoom. Pre-recorded and published lectures on you tube web sites or other channels. This form is valuable in all kinds of teaching, but especially valuable in a situation with hybrid teaching.

Our experience was that frequent use of group task and group discussion where the participants both were attending physically, and by Zoom, improved the communication between all participants and reduced the differences between those who were attending physically and those who were not.

Examples of student tasks for the days with individual/ group work

Example 1

Reflect on cultural and contextual differences in your own country.

Consider your own background, and how your background could be perceived by people from another geographical area and/or people with other socioeconomic backgrounds. Reflect on how your background may pose challenges and may also be a strength in your work in the field of mental health. You are not required to write down or share your reflections, but you are free to do so, and it may improve your learning and development to do so.

Example 2

Choose one research article (see suggestions below) and reflect on ethical challenges and solutions in view of existing guidelines and ethics in psychology.

Imagine that you have been invited to a conference to comment on the research ethics of the project that you have read about in your chosen article. What issues would you focus on? What were the strengths and weaknesses? How could it be done differently?

Example of a group task in communication:

You are part of the mental health and psycho-social support coordination group in a large refugee settlement on a Greek island.

There has been an assessment of children's (8-12 years old) well-being, where it was found that parents and teachers complain that many of the children have problems learning. They complain that the children don't sleep well because they have nightmares, they show disruptive behaviours, and struggle to concentrate. Some seem very nervous, while others are withdrawn and do not speak much. Many children suffer from stomach aches, headaches, and other physical complaints.

Your colleagues know that you are a TRT expert. In today's coordination meeting you have just been asked to plan for TRT intervention in a school inside the settlement, where there are only refugee children.

Consult the IASC guidelines. Where does this intervention fit into the guidelines? How would you plan the implementation of TRT? Make a 1-page note/plan with key words on how you will proceed. Note if there are considerations that you need to make, and if there is information you need to obtain.

You may keep this for yourself, and you do not have to share it. However, if possible, it may be a good idea to share it with a fellow student and compare your plans and considerations. It is also possible to send it to Unni and Ragnhild (in Canvas or by mail) if you wish.

For the group task the students were divided into random groups and had to organise the group work practically to overcome the challenges of technical difficulties and different time zones.

All of the student projects or group tasks were realistic and linked to real situations and contexts. Some were indeed real, in that the task was formulated in co-operation with an NGO, and the input given to the NGO to help their work.

Exams, Exam conferences and Final Project

The exams were all group exams where the knowledge to be tested was closely linked to the lectures. In addition, the skills in planning and cooperation in a team were essential, as was the ability to communicate with others. Typical exam instructions were:

On Monday 20th of September, we meet as normal. You will be given several exams questions but will only choose one of these. The questions (tasks) will be similar to the tasks you have been practicing already. You will receive the different options (questions) on Monday. You will also be divided into groups on Monday.

In addition to answering the task, you are asked to submit a brief report on the process of the group work, especially how you went about including all group members in the work, and how you managed to draw on the resources of all group members.

You shall send your final presentation to Unni and Ragnhild by e-mail by end of working day of Wednesday 23rd September. This could be a power point presentation, but you may also choose other ways to communicate.

On Thursday 23rd September, you will have a total of 45 minutes for your presentation, questions, discussion, and brief feedback on the group work. We suggest you keep the presentation itself to 20-30 minutes.

There will be an external examiner who will give you feedback.

Here are two of the exam options:

QUESTION 4 (OPTION 4) CHILDREN IN COX'S BAZAR

Background:

In 2017, many Rohingya people in Myanmar were forced to leave their homes, and over 1,000 people are thought to have died within one week. Most of those who survived settled in Cox's Bazar, Bangladesh. In camps throughout the area, nearly one million refugees have attempted to rebuild their lives. However, in the overcrowded and under-resourced environment this is very difficult, not least for children. In the 2018 Joint Response Plan for the Rohingya Humanitarian Crisis explicit references were made to the need to integrate MHPSS aspects into multiple sectors. UNHCR states that the various approaches can be unified in a system of multi layered services or supports to which various sectors (such as health, protection, education). Building on IASC and others, they state that one should distinguish between people whose symptoms may be transient or where minimal intervention will be sufficient, versus those who need more intensive or specialized clinical support. In such a stepped care model, subpopulations with different symptom profiles and severity are allocated to different levels of services and support.

According to the Convention of the Rights of the Child, all child refugees have the right to receive special protective services, specifically those that will help them cope with their experiences and rebuild their lives.

Your task:

You have been hired by UNICEF to work as a psychosocial advisor in Cox's Bazar. You will contribute to ensure children access their rights. Your responsibility will be to support programs throughout the camp that engage adolescents in productive activities, while at the same time, trying to protect

children from additional trauma. Your duties will include advising on the expansion of the adolescent centers in the camps, where adolescents are provided with skills-trainings of different types. You will also advise on the development and adaptation of MHPSS interventions, where community based psychosocial approaches should be combined with clinical approaches.

You will leave in two weeks. You are now planning for how to prepare yourself for this mission, and what information and prioritizations you think will be important for your first weeks in your new job. Make a presentation where you discuss your preparations, and what you think you will need to do, learn and priorities.

QUESTION 5 (OPTION 5). VIOLENCE AGAINST CHILDREN

Background

The UN Special Rapporteur on Child Protection is working on a report on the effects of physical, psychological, and sexual abuse of children for their development and health, and on recommendations on what can be done. He has a decided to call one chapter “why violence is a mental health issue”.

As you are active in a global forum for children’s mental health and have publicly argued that violence against children is a great threat to global mental health and a violation of children’s rights.

Your task

You have now been invited by The UN Special Rapporteur on Child Protection to a meeting on violence against children. The meeting is a side event to the 76th session of the UN General Assembly (UNGA 76) co-hosted hosted by Viet Nam, Norway and Nepal.

The rapporteur has sent you (and other groups and stakeholders) a list of issues he is addressing in the report and asks if you have input to any of these. In particular, he has for mentioned that he is looking for input to the below issues. However, he is consulting many sources, so you may choose to respond to only some, or you may choose other issues than these.

what type of violence is harmful?

what are the effects of violence on children’s mental health?

are there examples of violence from your country that could be used as examples?

an assessment of the evidence available on whether violence is in fact bad for young children

whether physical punishment harms children even when it is common practice

what can be done to prevent violence?

what can be done to support children who are victims of violence and promote healing

whether there are any examples of intervention of programmes that have positive effects, from your country or another country

On Thursday, you will present your input to the special rapporteur at a meeting in New York. In addition, to the special rapporteur, there will be representatives from UNICEF, WHO, and the UN delegations of Norway, Viet Nam and Nepal present.

For the crisis course, there were many practical exercises where the students learn skills and manuals, including psychological first aid and Teaching Recovery Techniques (TRT). The independence and freedom were increased gradually, allowing students to choose multiple forms of co-operation and use of resources. An example of a typical task was: Choose one of the following tasks, and also choose how to solve it (alone, in groups, reflections, written document, film, flyer, power point etc.).

1. You have been asked by a nongovernmental organization in your country (or choose a country/context) to advice on how to care for helpers. Define the organization and who the helpers are. Then make a one-pager (or flyer, or video) with messages to the helpers, e.g., a few topics to consider and bullet points of what they can do for themselves or their colleagues.

2. Make a summary (one-pager, flyer, video) of your own toolbox or ways to look after yourself. Reflect on this afterwards - what are your strengths? In what areas (where and how) can you develop further skills or tools?

You may leave your product below for others to see.

PSY381 CRISIS PSYCHOLOGY EXAM

QUESTION 1 (OPTION 1) PSYCHOSOCIAL SUPPORT IN AFHGANISTAN

Background

In August 2021, the Taliban assumed power in Afghanistan, with immediate repercussions across an economy already facing daunting development challenges. Even before the collapse of government, Afghanistan was facing daunting economic and development challenges. In addition, Afghanistan experienced a third COVID-19 wave starting in April. Many donors and partners, such as the World Bank, have frozen their aid to Afghanistan. Violence and conflict continue to threaten people's lives and health. Since the beginning of June, 120 000 children have been reported to have had to escape from their homes, and the total number of internally displaced people is now 3.5 million. More than 18 million people depend on humanitarian aid. According to World Food program 1 out of 3 Afghans do not have access to sufficient food. Winter is coming. Women in particular face many barriers in Afghanistan. It has previously been estimated that the majority of Afghan women are affected by at least one form of gender- based violence, although violence rarely is reported or recognized as a crime. Space to discuss GBV openly is limited, due to a highly gendered society. Being identified as a victim of sexual violence is risky and associated with stigma. Refuge outside the family is controversial. Medical and psychological interventions are limited. Psychotherapy is rarely available, and when available, it has been argued that neither disclosing details of violence nor most western psychotherapy methods resonate with local cultural understandings.

However, several initiatives exist, and there are several national and international organizations that continue their work. Norwegian Refugee Council (NRC) works on several of the problem areas above, including gender and protection. NRC coordinates the Afghanistan Protection Cluster and is part of the working group on Risk Communication and Community Engagement. NRC's protection unit continues to provide protection in camps, schools, and communities. This works includes training in psycho-social support and basic gender-based violence prevention for non-protection field staff.

Your task

As an expert on trauma and crises, you have been approached by NRC to advice on ways to support women and girls in camps. They want to develop a brief course for staff to increase knowledge about GBV and sexual violence and are interested in prevalence and consequences of GBV in humanitarian contexts. You have been asked to suggest how psychosocial support can be explained and outlined, both basic considerations, and more targeted and specialized support. You are asked to focus on the more specialized support, considering that there are very few trained mental health personnel available. You are asked to present alternatives to psychotherapy, for example group work, storytelling as an intervention, or available structured manuals. You have now worked on this for some time and will present an outline of the suggested course at a meeting. There will be about ten staff from protection and leadership at the meeting, none of whom are mental health personnel.

QUESTION 2 (OPTION 2) RAPID ASSESSMENT FOLLOWING FLOODING IN NEPAL

Background

Floods in Nepal are often induced by heavy rains causing landslides and flash floods. In the current scenario, heavy monsoon rainfall has caused flooding and landslides across different parts of the country, impacting more than 20 districts. The Ministry of Home Affairs reported more than 100 dead, 50 missing, and 150 injured in more than 400 flooding and landslide incidents. Over 10,000 people - half of them children - have been affected with an estimated 7,500 displaced from their homes. There are also a significant number of COVID-19 positive cases in Nepal. UNICEF has so far been responding to the immediate needs in the affected areas where landslides have occurred, providing blankets, tarpaulin, hygiene kits, water purification tablets etc. UNICEF is also planning to provide further support for landslide and flood victims, including psychosocial support.

Your task

UNICEF has hired you to conduct a mental health and psychosocial support situational assessment on needs, services and recommendations for supporting children in the affected areas. You are now ready to present your plan for this work. You will present an overview of the context, the goals, methods, and what types of results and implications you are likely to
find, as well as challenges and limitations that you have already discovered, or believe are likely. Your presentation will be for staff from the national and local government, including MOH, as well as UNICEF, WHO and representatives from the psychosocial task force, a total
of 20 persons.

Thus, the pedagogical strategies were many, and some were based on trial and error. The students were combining the academic reading and writing with experiential and cooperation effort. We also made an effort to create situations where the students were able to support each other, do peer review and develop multiple skills. Being a teacher

CHAPTER 10

PEDAGOGICAL CHOICES AND EXPERIENCES OF THE INTERNATIONAL SEMESTER

By Kerstin Søderstrøm

Since 2016 I have been involved in tailoring and preparing for the international semester to come true. The Covid-pandemic really put the program on test. Finally, in 2021 we could welcome five master students from Vietnam National University - University of Education to Norway to study global mental health and adverse childhood experiences together with Norwegian and Nepalese students.

Putting together an international collaboration and study program is a pedagogical choice in itself. When students and colleagues meet across cultures, we get both the outsiders view on what is taken for granted in our own cultural practices, as well as unique insights in reflections and ways putting knowledge into practice in various contexts. Emphasis on friendship and collegial collaboration is another pedagogical choice. A safe, supportive group is the best learning environment. One that welcomes and contains personal experiences and expression, one that can handle the members vulnerabilities and strengths and tolerates differences in learning and collaborative styles. Keeping one of the aims of the international semester in mind, creating an international collegial network for our students, we believe that friendship, experiencing each other ways of living, and the sharing of good moments, like Taco-nights and hikes to Ulriken, are main entrances.

These and more pedagogical choices were taken deliberately. Others were forced upon the international semester by the Covid pandemic and other circumstances. Travel and movement restrictions have rapidly made online learning and various digital tools a necessity in all levels of education. We praise digital solutions like Zoom, Teams and Canvas for making it possible to communicate and lecture relatively effortless in Kathmandu and Bergen at the same time. The tools make it easier to bring in expert lecturers from all corners of the world. A notable benefit is that international education and collaboration can be more environmentally friendly, less time and hazzles are lost in travelling, and availability to expert knowledge increases. The downsides are restrictions on the social dimensions and the full sensory experience of being in a novel place, the guest and host experience, the sharing of meals and laughs, informal conversations that can spark unexpected ideas and insights, the ingredients that go into making friendships.

Academia fosters student skills in first reading, listening, and then represent what is learned through writing, talking, and presenting, often in a PowerPoint format. In this International semester, we decided to give the students yet another tool to express themselves and their insights, the tool of Digital Storytelling (DS) (Lambert & Hessler, 2018).

Humans are storytellers. When our language skills are sufficiently advanced, starting around three years of age, we gradually turn to words and stories to contain and explain experiences. We build self-understanding and -presentation in a storied format. Learning and memory is fundamentally aided by the pegs of a story– what, who, why, when, where. Daniel Stern (1985) likened our mind with a journalist's work constantly trying to put these questions together in a coherent story. This is one reason why I wanted to explore DS as method. Another reason is to acknowledge the visual, emotional, personal dimension of learning. Then, there is the strength of visual media to convey

knowledge and information, and to stimulate engagement and reflection. Lastly, to engage the creative source and practical skills of the students.

The rest of the chapter will be dedicated to describing the methodology of Digital Storytelling and how it was used in the 2021 International semester.

Development of DS as method

The format of Digital Storytelling started as a method in California in the 1970ies while working with community-based documentary film production. The DG was used as an empowering tool aiding people to tell their story, find their voice and visual expression (Akre et.al., 2020). The method was inspired by pedagogical ideas from Freire and Boal and critical theory in adult education (Lambert & Hessler, 2018). The original ideas developed into the San Francisco Center for Digital Media, later named the Center for Digital Storytelling, and lastly, in 2015, the organization became, simply, StoryCenter (https://www.storycenter.org/). Since the beginning, DS is being used in various contexts, in educational settings (fex. Digital Storytelling – Diverse Project (diverse-education.eu), sharing of patient experiences (fex. Patient Voices – Insight through first-person stories…) and community activists, NGOs and user organisations (fex. The (Positive) Power of Digital Storytelling | HIV.gov). In the context of the International semester we orient towards scholarly digital storytelling (Wood-Charlson et al., 2015) and learn how to present projects and research using video, images, audio, music, and any other digital media.

Learning to create DSs

The training usually takes place in a three days-workshop. Our course was planned over two full days during a week's visit to Lillehammer and Inland University of Applied sciences. Professor Yngve Nordkvelle was in charge of the training assisted by Hans Brox. However, all were given access to the digital resources and preparations:

Start thinking about a story you want to tell related to your participation in the Global mental Health-semester so far. It can be anything, personal, social, cultural, from the lectures or readings, training etc. Choose something that made an impression on you and don't be afraid to be personal!

Start by jotting down keywords, free associative notes - and keep going on. The final story needs to be "boiled down" to approximately 300 words, but feel free to write a bit longer in the creative phase.

Start thinking about how you will illustrate your story: images on your phone, self-made illustrations, artwork, or images from the Internet – drawings often work well too! The course will address privacy regulations and proper use of images.

All participants were asked to bring their own devices, a smartphone, a wire to connect the phone to your Mac/PC, and a headset. The video editing tool used was "WeVideo, a free-version available at www.wevideo.com.

According to the StoryCenter there are seven key elements to keep in mind when creating a digital story (cited from Pennstate University libraries Home - Digital Storytelling - Library Guides at Penn State University (psu.edu):

1. Point of View: Before anything else, make sure you have decided what point you're trying to convey and what perspective you bring to this video. What is this story saying?

2. A Dramatic Question: Pose a question that your viewer can connect with their lives or experiences and provide a compelling answer.

3. Emotional Content: What about your research and its implications engages viewers emotionally, not just intellectually?

4. The Gift of Your Voice: Personalize your research to help the audience connect. Why are you well positioned to tell this story?

5. The Power of the Soundtrack: Don't forget about audio cues beyond your voice. How can music or sound effects immerse your audience, create a mood, or emphasize a point?

6. Economy: It takes a lot to hold someone's interest for over 5 minutes of video. Holding someone's interest for 2-3 minutes is much easier. Keep it no longer than a video you'd want to watch.

7. Pacing: The rhythm of the story and how slowly or quickly it progresses. Trust your own sense of what works. Is it entertaining and well-paced to you?

Digital stories from the international semester

As with many plans this semester, the scheme was constantly under attack by changes and extra requirements related to Covid, tests - and travel arrangements. Unfortunately, the VNU-students had to make an early return home and participated via Zoom. The Nepalese students were not able to reserve the needed time for the DS-training. The very practical training had to be adapted to a hybrid course for on-site and e-learners. Within the short week between the exam of the second course and departure for the project/practicum in Nepal, the Norwegian students completed the training on site, and the Vietnamese while in quarantine with noise and people around at all times. The quick learning pace and the dedication to complete the training were amazing. One student had to stay awake until the middle of the night to record the soundtrack without disturbances. One had to resort to the most private and quiet place, the toilet, to do the voice over. The students drew from various sources, from immediate, significant, funny, and challenging experiences. With a good understanding of what a digital story can do, they managed to combine the personal with more general messages. Many stories attend to the experience of being an exchange student and making friends across borders and cultures. The stories are testimonies of the impact of international student exchange, the importance of being challenged – and dive into life, preferably with good friends and guides along.

The DS are linked below as a resource for remembrance, a good laugh and deep reflexion.

Name	Link to Digital story
Lea Grøstad	https://www.wevideo.com/view/2446228482
Vilde Standal Borgen	https://www.wevideo.com/view/2446260832
Hue Hoang Thi Thanh	https://www.wevideo.com/view/2447474222
Tam Nguyen	https://www.wevideo.com/view/2450535614

Dao Hong	https://www.wevideo.com/view/2452451807
Trang Le	https://www.wevideo.com/view/2452575237
Kajsa Sagnes Matthäus	https://www.wevideo.com/view/2452991512
Nguyen Phuong Hong Ngoc	https://www.wevideo.com/view/2454141721
Ella Marie Roll-Hansen	https://www.wevideo.com/view/2456909717
Paula Marie Olsen	Delivered by mail – no link
Nora Blomkvist/Julie Taule Erichsen	https://www.wevideo.com/view/2457099169

DG - a pedagogical tool for GMH learning and doing?
Initially, we planned a DS-dissemination from the project and practicum. However, with the outbreak of the new Omicron Covid-mutant resulting in new constraints that again challenged plans, deadlines, and the students' capacities to adapt to the unforeseen, this delivery was cancelled. Hence, we didn't get the full experience of doing academic DSs presenting the projects. The training DSs are considered a valuable experience on how to tailor a DS. The DSs can be used together with information in recruitment-processes to the NORPART scholarships and the international semester on Global Mental Health at Centre for Crisis Psychology at University of Bergen.

With more time and less practical stress around the training we would have dived deeper into the story circles and how to adapt the method to academic projects and dissemination. Further testing out will provide a more well-funded answer to the usefulness of adding Digital stories as a pedagogical tool for the NORPART-projects and the Global Mental health semester.

My own reflections are related to the responsibility of reaching out with knowledge. Traditional academic writing and conferenced presentations are tailored for the in-group, the already knowledgeable and those familiar with the format and genre. The formats rely heavily on words and do not necessarily team up with the storied nature of mind and memory. In general, in knowledge sharing, and possibly even more so in the field GBH, the challenge is to reach a wider audience. Visual media and short digital stories with room for emotions can play a role in filling this knowledge transference and transmission gap.

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CHAPTER 11

LESSON LEARNT: INTERNATIONAL COPERATION IN HIGHER EDUCATION

By Prof. Mita Rana

Background
The NORPART grant was approved for period 2019-2023 with the aim to enhance the quality of higher education in mental health in Nepal and Norway, to strengthen internationalization of higher education through mobility of master/ PhD students and academic personnel.

It is important to name significant persons; Dr. Suraj Thapa from University of Oslo (UiO), Prof. Dr. Saroj Ojha from Tribhuvan University (TU), Institute of Medicine (IOM), Prof. Jarle Eid from University of Bergen (UiB), Dr Cecilie Javo from University of Tromso, Dr. Arun Kunwar from Kanti Children Hospital (KCH) and many others who came together for this noble cause of bringing this collaboration to reality. This has been possible due to continuous, relentless efforts and vision of Dr. Suraj Thapa, to contribute to the enhancement of the academic and clinical sector of mental health in Nepal.

Meeting with Prof. Jarle. at our office, Department of Psychiatry and Mental health (IOM/TU), in Dec.18, 2017 was the very first step towards exploring into the possibilities of student exchange between clinical psychology students from the two countries. This meeting was facilitated by Dr. Suraj Thapa and Dr. Rishav Koirala, (PhD scholar at UiO, and former resident in MD Psychiatry from our department).

We were delighted to hear that there could be possibilities to work and plan for student exchange for clinical psychology students also, since there was already some planning for PhD and exchange program for psychiatry residents. We envisioned and were hoping that our students in clinical psychology would also get the opportunity to pursue their PhD in Clinical psychology through the Norpart project as well, but this didn't materialize, and we were still very content with master level student exchange program.

It was a very happy moment for us when we heard that our joint application for the Norpart project proposal had been accepted. There were series of meetings, both virtual (zoom meetings, skype) and in person visits of faculties from both countries. We had faculties Prof.Jarle, Unni Helgnete and Ornulf Lillestol from UiB, visit our department. They participated in our curriculum review meetings as well as observed prospective residential sites for Norwegian students coming to Nepal. I got the opportunity to visit the Centre of Crisis psychology at UiB, Norway in May 2019. Meetings with faculty at Centre of Crisis Psychology, UiB were mainly focused on schedules, and I also got the opportunity to meet with the Rector and Director. I interacted with students at the center and gave a presentation for the students on 'Psychology education in Nepal'.

While scheduling and planning were taking shape and the first batch of student exchange was planned for August 2020, the COVID pandemic struck. Nobody had expected the conditions would be so bad but it certainly was, globally.

Program

The covid pandemic affected the programs and adjustments had to be made. We were forced to wait and postpone our plans. However, our project partners at UiB were working on possibilities on online classes for students. It was possible due to UiB's optimistic approach, and hence five of our clinical psychology students got enrolled in the international semester course (Aug-Dec.2020) in Crisis psychology and Global mental health at UiB, Centre of Crisis psychology by virtual method. This was an added advantage for our students. Though the students didn't get to visit Norway, they gained a lot from being part of a complete international semester, i.e. mode of teaching; teaching learning activities, working in groups & assignments; getting to hear and learn from key persons working in various fields directly linked to crisis psychology and global mental health. In 2021, four more graduates of clinical psychology from Nepal have got the opportunity to participate and complete this online international course.

This year, seven students from UiB have visited Kathmandu for a month during mid-November till mid-December, as part of student exchange program. Four of them were part of this Norpart project between Norway and Nepal. In addition, there were three more students who were supposed to visit Vietnam under the Vietnam- Norpart project but could not visit due to travel restrictions in Vietnam.

Schedules had been planned for the visiting students to provide them with maximum exposure and learning. The students have had to adjust to a very different culture, society and work environment at the hospital and around multiple sites they visited. It mainly focused on visits to various NGO's /sites, organizations and hospitals working in mental health. They observed the clinical psychological services at TU Teaching Hospital (TUTH) which included clinical interviews, case work up, counseling/ psychotherapy and assessments of clients visiting the out -patient department (OPD) and in- patient ward, where they observed both psychiatry and clinical psychological services provided in coordination simultaneously. Students also participated in case conferences where they observed detail case discussion focusing on case history, psycho-diagnostic assessments and planning of psychotherapeutic interventions.

Among various NGO's working in psychosocial and mental health sector, they visited KOSHISH, TPO-Nepal, ICDP Nepal and CWIN (Peace home, helpline center). Students also shared and exchanged their experiences among students at IOM and at TU. They also conducted two orientation programs on Trauma Recovery Technique (TRT) for students at Master in Counseling Psychology Program and Master in Psychology at Padma Kanya (Girls) College at Tribhuvan University. This interaction and exchange was very well received from students of both Universities.

Apart from course related visits, students were able to visit various cultural heritage and tourist sites in and around Kathmandu. I am quite sure it has certainly been culturally and educationally experiential for them.

Lessons learnt

Even though the covid crisis itself brought multiple uncertainties we tactfully came up with alternative plans amidst covid crisis. Though Students from Nepal were unable to visit UiB Norway we were very happy to have the first batch of Norwegian students visit us. It surely is an example of how a crisis situation can be tactfully handled, i.e., implementing the skills and truly being able to cope and experience an ongoing crisis situation in a very different culture and society, in Nepal, a country where covid was not spared. For the Master of Philosophy students in Clinical psychology from Nepal the course has broadened their knowledge and insights on evidence-based perspective, i.e. focus on implementation, coordination and collaboration. The students and graduates who attended online international seminar at UiB shared that the course was useful and has broadened their global

perspective. If online classes can be so effective, the hybrid model in which they get chance to take course both online and in person (visit to UiB) would have been even more effective.

Now we intently look forward on planning on sending the Nepalese clinical psychology student's to UiB next year, where in between the scheduled activities it will be very useful for the students to get acquainted to clinical psychology education and services in Norway.

The Norwegian students shared their experiences and learning during their observational posting at TUTH, Kanti Children's Hospital and visit to various organizations working in mental health and psychosocial support in Nepal. Their feedback has been well received by us and we will incorporate in future. Similar package can be continued for coming years too.

It will be plausible to state, since the planning was based on the improvement of covid crisis situation, there were certain last moment planning and logistic hitches. These were jointly and efficiently sorted out.

Conclusion

In my concluding note, I must say, the four weeks was rather short and concise though we planned it in a way so that the main objectives of the exchange program were achieved. Though time has passed rather quickly, it is just the beginning of learning and sharing which we hope to continue. We hope students will take with them fond and insightful memories of mental health scenario, as well as social and cultural realities of Nepal. We hope this project will open up many more opportunities for the students and it will provide students additional insights and interests for their career and future prospects. We wish them all the very best and remain grateful to all those directly involved and all those who have contributed largely behind the scenes to make this project possible.

PART 3

CHAPTER 12

Students home tasks, exams – about the technical part of the cooperation and learning – perspectives

By Gracjana Plociennik

A lot of the general information, the organization of tasks and classes are mentioned in chapter 8. I will go through them again for a quick refreshment, as well as my, as one of the students, understanding and experience of the program.

So, this program/semester is a Norwegian partnership program for Global Academic Cooperation (NORPART) and is funded by the Ministry of Education and Research and the Ministry of Foreign Affairs. The aims are to strengthen and enhance the partnership and quality of higher education in Norway and partnership with developing countries. As well as enhancing t internationalization and mobility of students between Norway and partnering countries. It focuses on collaboration, building a broader and mutual understanding of global mental health, and what place it has in the world and at different places.

The program offers international study opportunities, helps to explore the cultural meaning of childhood and conceptions of adversity and developmental support. It teaches how to provide psychosocial support in crisis and disaster and links mental health to sustainable development at individual, community, and global scales. The program gives a cross-cultural experience, where the culture is embedded in human mind and behavior. It broadens understanding and conception of oneself and other people, as well as provides education on crisis and trauma (i.e., abuse, neglect, malnourishment, where natural disasters constitute threats to childhood) (Safe & Sound, 2021).

The program covers a lot of the important topics in a short period of time. This means it is an intense semester. The semester is divided into two courses, the Introduction to global mental health (PSY380), and Crisis psychology and disaster response (PSY381), and ends up with a project and exchange (travel and work in the chosen country from the partnering places). Before starting the semester, you go through an application process where it is decided what country you are going to. Students are then divided into small groups of two. Partnering countries are Nepal, Vietnam, South Africa, and Thailand. Ideally, this is the plan, but because of COVID-19 and the present pandemic we had to change the plans and adjust. We received students from Vietnam here in Bergen, Norway, and UIB was able to send Norwegian students to Nepal. This program not only covers important topics but also gives a great opportunity for working in teams, learning from each other, for coordination and collaboration. It teaches you how to be more open to different perspectives, broaden your understanding of mental health, how things work from an organizational perspective and from different angles.

The course is led by Unni Marie Heltne, senior advisor at the Centre for Crisis Psychology, and Ragnhild Dybdahl, Associate Professor in global mental health. Through the course, we also had an opportunity to listen to other amazing and knowledgeable people, such as Prof. Mita Rana, prof.emerita Nora Sveaass, prof. Dang Hoang-Minh as well as to our external examinator Christine Mbabazi, Kerstin Søderstrøm who is also responsible and a big part of the program, and many others. The semester consists of lectures from 9-12 on Mondays, Wednesdays, and Thursdays. Other days are filled with individuals work such as reading and group work with role-plays, presentations, discussions, making videos, etc. I must say that group work is the focus of this program. And it is done in a way that everyone can work and get to know everyone, so the groups are changing on every task. The class consists of around 20 students. The small class gives the opportunity to create a home, and comfortable place for everyone, and you really get to know all students, and well as a direct connection with professors. This gives a feeling of being a part of something important.

As mentioned, tasks are mostly done in groups, and then discussed in class. There is no pressure on getting the best grade, but to understand and put as much energy into the tasks as you like. As Ragnhild mentioned there is no point in the grading system in this course, it is about gaining knowledge and giving as much as you want to this course. The course starts with a communication topic, on how to communicate mental health with the public and politicians and moves on to other topincs, such as mental health challenges in different countries, research ethics, reflection on cultural and contextual differences, and on learning about training manuals and much more. The tasks really give an opportunity to be included in the teaching part and engage everyone in doing so. By this we take an active role in the teaching and learning process. The class dynamic which we had, focused on safety, warmth, on being comfortable and made the teaching and learning easier. There is always room for questions, discussions, and for exchanging perspectives.

The same goes for the exams. The exams are also group work, where we were presented with 5 different topics to choose from, make a presentation, and present it to the class, professors, and our external examinator. In the first exam all the groups chose the same topic. It was interesting to see how the different groups solved it differently.

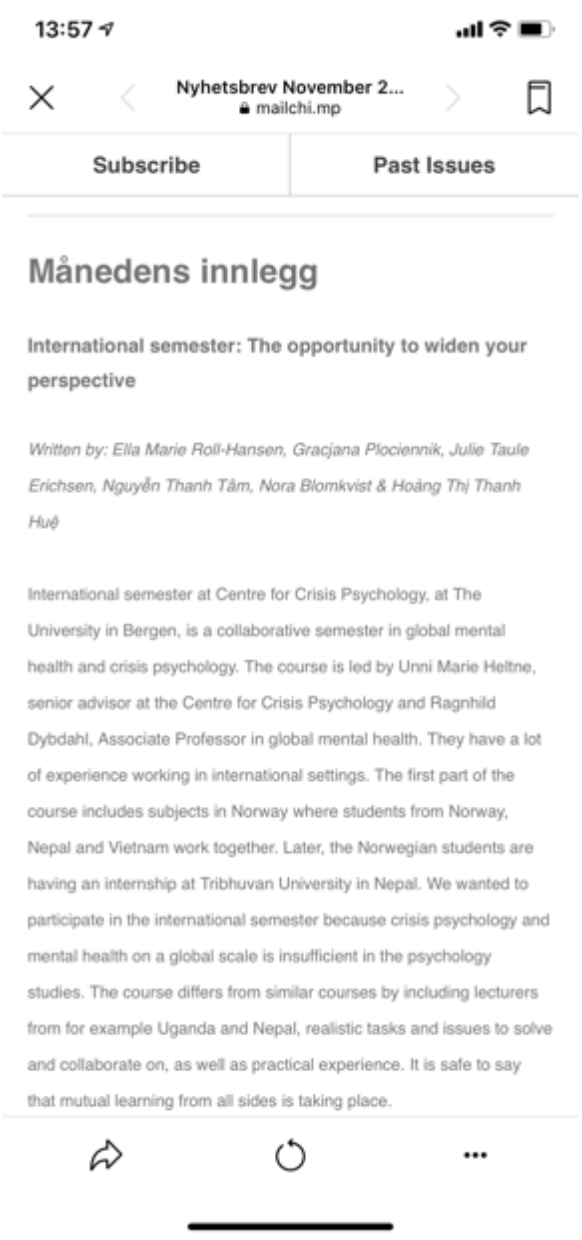
As I give this summary of the semester, I want to present some of the screenshots of the front pages of the presentations we made for the exams at the end of the chapter.

Of course, we could not avoid challenges in collaboration and teamwork. Challenges that were mostly due to technical issues, the distance, time difference, etc. Challenges can help you grow, and this time was no different. Through challenges, both small and bigger and through traveling we really learnt about human nature in a way you will not be able to learn from only books. We all agreed that this semester should obligatory and a part of the general psychology study program that we have in the universities. This course shows how context, preparedness, knowing your role, principle of not doing harm, even the unintentional one, play an important role when working in global mental health. A lot was done already but the awareness of mental health is still talking baby steps, and much more must be done.

What is also worth mentioning is that the tasks are relevant to real-world problems, the situations here and now, such as a pandemic and the situation in Afghanistan. We even got a task to solve and propose how to support schools in Ethiopia so that they can better support children’s health and psychosocial wellbeing. This was a real task that Ragnhild got in her email. The tasks also give an opportunity to see if this is something for you, working on an international basis. Other topics that we covered includes human rights, mental health awareness, understanding individuals within their context, lived experiences, emergencies and working in emergencies, ACE studies, the ethics (code of conduct) and much more.

Here are some pictures of the exam presentations, and an example of the topics we covered.

Here is also the post we made on the international semester. November 2021. Nettverk for global mental helse. https://mailchi.mp/cf2e44e25637/nyhetsbrev-november-2021-fra-nettverk-for-global-mental-helse-i-norge?fbclid=IwAR1p-MDVF16czFXPSeSdU7Yje4jfm2AKEJyL5qbmHVThHxkPDOjf5pnjLi0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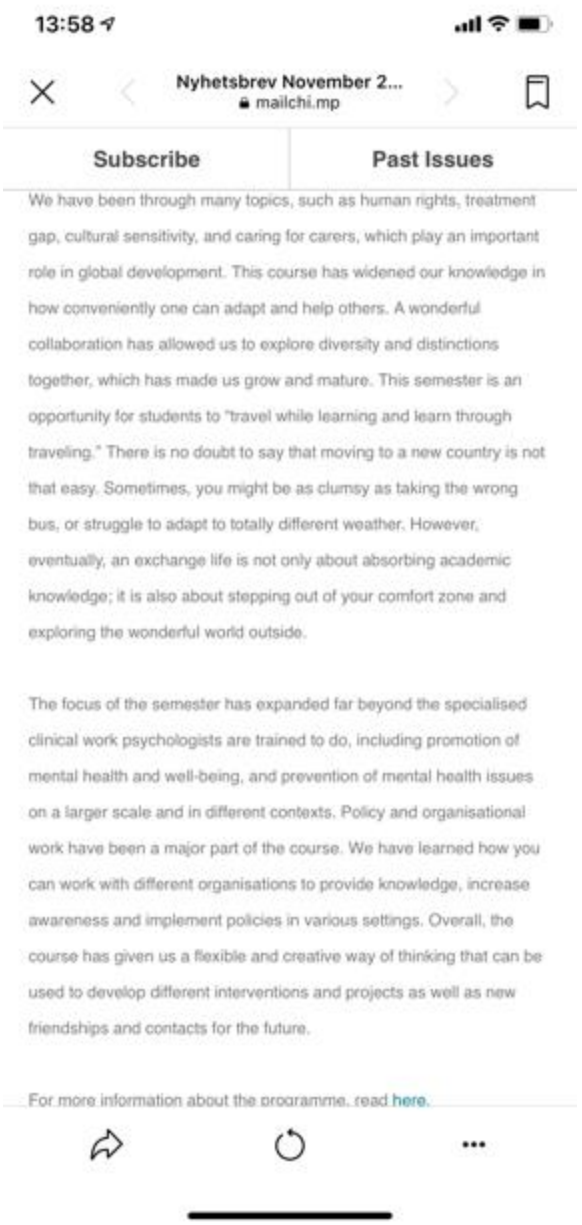
Past Issues
Månedens innlegg
International semester: The opportunity to widen your perspective
Written by: Ella Marie Roll-Hansen, Gracjana Plociennik, Julie Taule Enichsen, Nguyễn Thanh Tâm, Nora Blomkvist & Hoàng Thị Thanh Huệ
International semester at Centre for Crisis Psychology, at The University in Bergen, is a collaborative semester in global mental health and crisis psychology. The course is led by Unni Marie Heltne, senior advisor at the Centre for Crisis Psychology and Ragnhild Dybdahl, Associate Professor in global mental health. They have a lot of experience working in international settings. The first part of the course includes subjects in Norway where students from Norway, Nepal and Vietnam work together. Later, the Norwegian students are having an internship at Tribhuvan University in Nepal. We wanted to participate in the international semester because crisis psychology and mental health on a global scale is insufficient in the psychology studies. The course differs from similar courses by including lecturers from for example Uganda and Nepal, realistic tasks and issues to solve and collaborate on, as well as practical experience. It is safe to say that mutual learning from all sides is taking place.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We have been through many topics, such as human rights, treatment gap, cultural sensitivity, and caring for carers, which play an important role in global development. This course has widened our knowledge in how conveniently one can adapt and help others. A wonderful collaboration has allowed us to explore diversity and distinctions together, which has made us grow and mature. This semester is an opportunity for students to "travel while learning and learn through traveling." There is no doubt to say that moving to a new country is not that easy. Sometimes, you might be as clumsy as taking the wrong bus, or struggle to adapt to totally different weather. However, eventually, an exchange life is not only about absorbing academic knowledge; it is also about stepping out of your comfort zone and exploring the wonderful world outside.
The focus of the semester has expanded far beyond the specialised clinical work psychologists are trained to do, including promotion of mental health and well-being, and prevention of mental health issues on a larger scale and in different contexts. Policy and organisational work have been a major part of the course. We have learned how you can work with different organisations to provide knowledge, increase awareness and implement policies in various settings. Overall, the course has given us a flexible and creative way of thinking that can be used to develop different interventions and projects as well as new friendships and contacts for the future.
For more information about the programme, read here.

References

Safe & sound. (2021). Retrieved December 21, 2021, from https://www.safeandsound.world/about/

CHAPTER 13

EXCHANGE AND NON-EXCHANGE

By Gracjana Plociennik – with help of my fellow students who contributed with their experiences

The whole semester widened our knowledge and expanded it far beyond what we could ever imagine. The knowledge about what specialists do, governmental organizational engagement, and the non-governmental organizations, and how much we have to "fight" for mental health for it to be more and better acknowledged. Besides the obvious part of the courses – the studies- we made friendships for life. The exchange part of the program is a main part for this semester. It is exactly about internalization and mobilization of students.

We had the opportunity to get to know each other, spend time out of the classrooms, and get to know the "less professional and serious" part of one another. We managed to exchange perspectives, traditions, talk about differences and even some similarities.

Meeting a group of people from very different countries, and from a far away, creates different thoughts and expectations. The main question for most of us was: *Will we be able to connect with one another, and create friendships, besides the differences each of us hold?* I still remember my first interview when applying for this semester. As the one student from Lillehammer, it was made clear what the expectations for me was being a good host, to greet and welcome the students from Vietnam. The pressure was on, but it was a good pressure. It was exciting being a part of an international exchange and being able to meet new students from other parts of the world. Unfortunately, our Nepalese students could not travel to Norway, because of the COVID-19 situation. But we were lucy enough to welcome students from Vietnam, and the Nepalese students participated digitally.

First we met the Vietnamese and Nepalese students on Zoom and later our Vietnamese friends sitting around the table with us. Besides the challenges, technical ones mostly, it went well, we could hear each other's, and easily discuss topics, and exchange ideas, perspectives, as well as laugh – one thing that should never be forgotten. The differences, the cultures, contexts, and even different stages of education that a lot of us hold, made us more curious and open. We sat together, listened and learned from each other. We shared and cared for one another. The patience, language, openness, listening, sharing and creating a good and safe atmosphere were some of the main characteristics that we could practice together, as well as getting out of the comfort zone and working remotely became the new normal.

My first meeting with the Vietnamese students was at the dorm. I was waiting for them to walk together to class. This was the first, in real life, meeting. It was lovely and my immediate thought was, *how sweet they are.* Later I was also invited for dinner at their floor (as we lived in the same dorm, just different floors), where they cooked delicious traditional dinner for me. When the first meeting happened, all the questions and apprehensions went away - as I speak for all of us. Icame to Bergen from Lillehammer and felt very much welcomed by the other Norwegian students. This gave great expectations on how the semester might go on further.

One of the first meetings that all the students – Norwegians and Vietnamese – were able to attend was the *famous taco night*. As many of us had different thoughts and expectations and even doubts what to expect, that night all of us bonded over the “famous” Norwegian taco, where we shared the tradition and folding techniques with our Vietnamese friends. We ate, talked, listen to music, and had a lot of fun. We exchanged thoughts and norms about relationships in both countries, and found many differences on what is common and expected and learned a lot from each other.

After the taco night we spent a lot of time together. In classes and outside of the classes eating pizza and sushi dinners, café meetings, studying together and trips to the mountains. These memories will never be forgotten.

Exchange: Vietnam-Bergen

The Vietnamese students describe Norway and Bergen as very calm and not crowded at all. With the differences in population between Hanoi and Bergen, we understood that Bergen was aquiet place which the Vietnamese students liked a lot. They mentioned how nice it was that busses came on time and that bus tables made it possible to plan the travel.. This was very different from the Vietnamese busses where you just try to rush and catch the bus. Differences in climate and the weather was a popular topic to discuss. Bergen is known for its rainy days, and the weather did not spare our friends. But that did not stop them from enjoying and exploring Bergen and Norway. They even managed to experience northern lights one day in Bergen, which isa big experience, especially in the center of the city.

From catching the wrong bus, to not so favorable weather and to the friendships and memories we all experienced, we became aware of the differences and similarities in cultures. These experiences made us grow and learn through meeting students with different backgrounds.

Exchange: Bergen-Nepal

At the end of the program, some of the Norwegian students from UIB got the chance to travel to Nepal for four weeks and practice what they had learned in the courses. The travel process was not an easy one especially in such fragile situation as the pandemic, but in the end it all went well. All the students got their visas, vaccines, and all the necessities for the trip. The Nepalese climate is very much different from Norway. The days are quite warm, reaching to 25 celciusdegrees, and nights are being cold. You must pack for all weathers, which is challenging. With the help from fellow Nepalese students and the teachers it was easier to know what was necessary to pack.

The traveling day came, and as the students landed in Nepal, they felt really welcomed by the fellow Nepalese students.. From showing the direction, helping manage the differences and give recommendations for things to do on the spare time, as well as the support at the work field, the Nepalese students were really helpful. And it was great to finally meet all of them in real life, and not only on the screen. THe Nepalese students also joined in exploring several places, and how fun all of them had – which is ve. All the fun we had together is very much seen on the pictures at the end of the report.

Fun aside, the work had to be done as well. This was challenging at times. The adaptation, knowing and not knowing what to do and how to do it was a real challenge. Not only working in a different country and culture, but coming to a different country can feel chaotic at times. Everything can feel completely new and different from the things we are used to. It was a lot to take in, new and different impressions to be made. People have their own ways of doing things, norms, rules and more. This, at times, can be overwhelming, which is completely normal at the beginning. The support from the group,

and the warmth they received played a crucial role in making things better. It made it easier to come into a routine, the norms, get to know the culture, and as one student quote, *One might even end up liking things that were scary, challenging, confusing and difficult at the beginning.* But as with most things, the beginning can be scary, confusing, challenging and even difficult, but with learning comes wisdom and experience. And this time was no different.

Exchange – non-exchange

When the exchange part happened for a group of the students, some of us were not able to travel. The travel part was initially a big and the most exciting part of the whole semester. However, the semester program is organized in a way that everyone will get a lot from the courses, even without traveling. We managed to meet amazing and very knowledgeable people, read, listen, and learn about important subjects, that some of us did not even think about when studying psychology before. This show how important and necessary these subjects really are. The two first courses are there to prepare us for the project and working in internationally. As thepractical part is important, we got to practice on each other, such as trying to convey the manuals for children. We challenged each other with the roles of children and helped one another to find ways to manage some of the difficult/challenging/chaotic situations that children can create. We were also presented with a lot of examples from real life, which made it easier to understand the context and concepts.

As not being able to travel, I understand that the exchange and internationalization happened really in two ways. Firstly, the physically traveling welcoming students here in Norway, and secondly the digital internantinalization we all experienced. The global aspect in this semester focused on adapting, flexibility, and making the best we can out of the situation we were in. Not being able to travel physically did not stop us from getting to know each other ,sharing and becoming friends. This international semester gives opportunities for friendships and for future work and cooperation. As I confidently can say, all of us experienced and enjoyed the whole program to the fullest.

CHAPTER 14

A MEMORABLE EXPERIENCE SAVED ON PICTURES

PICTURES FROM BERGEN

MEETINGS IN CLASS AND ON ZOOM

MEETINGPOINTS IN BERGEN

TACO NIGHT

THE CONCERT – HEDDA MAE

TRIP TO FLØEN

THE AQUARIUM

AND MUCH MORE OF EXPERIENCING BERGEN


DALE OF NORWAY

LAST DINNER

PICTURES FROM NEPAL


WHOLE CHICKEN

GREETING FROM LILLEHAMMER

FAMOUS MEME MADE BY THAM


UNIVERSITAS
BERGENSIS