1. Title and Project coordinator

Mental health in post-conflict Colombia – ways ahead. Project coordinator Jens Modvig

2. State of the art and rationale

The civil war in Colombia has been the longest running conflict in the Western Hemisphere (McFee 2016) and has influenced the lives of almost all people in the country (Nussio et al. 2015, Moffett 2016) in terms of high levels of inequality, social exclusion, political processes, and unequal distribution of land ownership (Historical Commission of the Conflict and its Victims 2015). A peace agreement was signed by the government and Fuerzas Armadas Revolucionarias de Colombia (FARC) and approved by the congress in November 2016 after almost five years of negotiations. Now, and in the years to come, the implementation of the agreement will be carried out.

For some people, joining the illegal armed groups has been a way to survive and obtain employment, education, financial improvement and security (Hernández-Holguín and Alzate-Gutiérrez 2016). Currently, many of the ex-combatants face economic hardship and stigma preventing their reintegration into family and community (Denov and Marchand 2014, McFee 2016).

Mental health studies in ex-combatants and the victim population show a higher prevalence of post-traumatic stress disorder, anxiety, depression, abuse of substances and alcohol, and aggressive behaviors, among others (IASC 2010, Hinkel 2013, Baingana & Bannon 2004, Dickson-Gómez 2002, Odenwald et al. 2007, Winkler 2010 and Wererstall & Neuner 2013). A national mental health survey was conducted in 2015 showing a high prevalence of mental health problems, primarily within highly violent municipalities (Gómez-Restrepo et al. 2016). The study showed that more than 40% of respondents from all regions of the country reported having felt discriminated against at some time in their lives due to e.g. having a mental problem, being a victim or having been a member of an illegal armed group. Failure to address mental health and psychosocial disorders in populations that have experienced mass violence and trauma caused by conflict will impede efforts to enhance social capital, promote human development and reduce poverty (Baingana 2003). There is often a huge gap between those experiencing mental health problems and those receiving treatment. This is being addressed by WHO through the Mental Health Gap Action Programme (WHO 2008).

Health-related stigma has been researched both in terms of theoretical development and impact (Deacon 2006, Goffman 1961). It is well documented that such stigma meets all the criteria to be considered a fundamental cause of health inequalities (McDaid 2010). Studies of conflict-related stigma are less prevalent, but its negative effect has been documented. To date, no research exists on how stigma is shaped in the framework of post-agreement with the FARC and the subsequent peacebuilding process, nor evidence in relation to interventions that respond effectively to the needs of conflict-victims and ex-combatants. More empirical research in the ways stigma operates to shape population health is needed, including mechanisms to reduce stigma and promote social inclusion (Evans-Lacko et al.2014) and how to undertake this in a cost-effective, sustainable, and patient-centered manner (Tol et al. 2011).

The peace agreement in Colombia has established a momentum for targeting many of the problems caused by the conflict. The challenges include addressing mental health and conflict related trauma as well as stigmatization and massive social exclusion of vulnerable groups

(Final Agreement 2016). Steps have already been taken, e.g. through the establishment of the Colombian Agency for Reintegration (Agencia para la Reincorporación y la Normalización - ARN), which provides support to the demobilized people (McFee 2016). Also, the government's ten-year plan for public health 2012-2021: *Health in Colombia, you build it* includes an inter-sectorial and community based approach to mitigating mental health consequences of the conflict (Ministerio de Salud 2012). However, there is a need to get a deeper knowledge of the specific needs and resources in the territories, and a need for empowerment with the aim of securing the sustainability of the interventions strengthening the local networks of services related to mental health and coexistence in the context of post conflict and in perspective of peace building.

3. Relevance

One of the health related challenges facing the government during the peacebuilding process is institutional strengthening to improve effective access to comprehensive care services within the framework of the Comprehensive Health Care Policy (Política de Atención Integral en Salud - PAIS) and its Comprehensive Health Care Model (Modelo Integral de Atención en Salud - MIAS). The PAIS requires an operational model with the development of strategies for guaranteeing the right to health. This includes promoting community and intersectoral action for the construction of more inclusive and protective communities. The problems must be addressed in a coordinated effort by civil society and public institutions, thereby helping to secure a sustainable reintegration of ex-combatants and internally displaced people into the community and reduce the risk of future rearmament and violence.

The project is in line with the general objective of the PAIS, that is, guiding the health system towards the generation of the best health conditions of the population by regulating the conditions of intervention towards "access to health services in a timely, effective and quality way for the preservation, improvement and promotion of health". Furthermore, the principles defined in PAIS include equality of treatment and opportunities in access (principle of equity) and the integral approach to health and disease, consolidating "the activities of promotion, prevention, diagnosis, treatment, rehabilitation and palliation for all the people".

The present research project will thus contribute to the implementation of the Comprehensive Health Care Policy (PAIS), by providing knowledge and tools for local approaches to the mental health needs in the post-conflict territories. The project entails a multi-disciplinary research-based approach through addressing the support needs and preferences of the stigmatized and marginalized groups, taking into account social dynamics and historical and territorial contexts and also the resources of the target population and their communities. Likewise, the project is aligned with the ten-year Public Health Plan 2012-2021 through the promotion of mental health and coexistence, well-being and human and social development. Thus, the research links mental health, post-conflict healing, and reintegration of stigmatized groups in a low income post-conflict setting.

The project's focus on stigmatized and marginalized groups including minors coincides with the overall approach of the Sustainable Development Goals: Leaving no one behind. More specifically, the project will contribute to targets 3.8 (universal health coverage) and target 16.1 and 16.2 (reduction of violence including abuse, exploitation, trafficking and torture of children).

4. Objectives

Development objective

Improved mental health in post-conflict Colombia contributes to building a peaceful and democratic society

Immediate objective

Mental health is improved in vulnerable and stigmatized groups in conflict-ridden areas of Colombia through effective knowledge- and evidence-based focused interventions that respond to the needs and preferences of the population

5. Expected outcomes and outputs

Outcome 1

Research-based knowledge about vulnerable populations including the dynamics between stigma, social capital and mental health, has been generated, to guide the design of focused interventions

Output 1.1
Increased knowledge about the territorial distribution and characteristics of the vulnerable and stigmatized groups

Output 1.2
Increased knowledge about vulnerable and stigmatized groups' violence exposures, treatment and support needs, health-seeking behaviour, and preferences for health care and community reintegration

Output 1.3
Increased knowledge about social dynamics shaping stigmatization including potential predictors for successful mental health treatment and community reintegration of vulnerable and stigmatized groups

Outcome 2

The health care system has implemented innovative and evidence-based outreach interventions which effectively strengthen mental health in vulnerable and stigmatized groups

Output 2.1
Focused outreach interventions aiming to improve the mental health of vulnerable and stigmatized groups have been designed and implemented on a pilot basis

Output 2.2
A monitoring and evaluation (M&E) system for follow-up on the course and impact of the outreach interventions has been established

Output 2.3
Pilot outreach interventions have been evaluated, and recommendations for mental health and social inclusion interventions within public health policy planning have been provided

Outcome 3

Research capacity among project partners has been strengthened

Output 3.1
Local health care providers have gained knowledge on how to collect, analyze, and use data in their daily work

Output 3.2
Colombia Ministry of Health has increased its capacity to engage with private research institutions and its capacity to work evidence-based when designing mental health policies and interventions

Output 3.3
Universidad Externado has increased its capacity to engage in partnership with public institutions on the use of research results, its capacity in mixed-methods research in mental health and its capacity in evaluating interventions

Output 3.4
Dignity has increased international research experience and ability to transform results of needs assessment surveys into national intervention strategies and interventions

6. Methodology

The project design is a mixed methods study, with a quantitative and a qualitative component. The study and the subsequent pilot intervention will be undertaken in five departments of Colombia, selected based on population composition and exposure to the armed conflict. The study will provide data on the health needs of the population, in particular stigmatized and vulnerable groups, their preferences for accessible and appropriate health services, their social and community resources, and the dynamics of stigmatization with respect to health-seeking behavior.

During the initial steps of the study, existing data and health information systems will be analyzed. These data include, inter alia, the Ministry of Health (MoH) Analyses of the Health Situation (ASIS) and the Territorial Health Plans (PTS). The National Mental Health Survey from 2015 will also be considered in-depth, and the possibility of running specific analyses on the large dataset for this project has already been secured. In particular, analyses identifying groups with high mental health needs and low consumption of health care services would be of great interest. Further, the departments selected for the mixed-methods study will be mapped in terms of health and community resources. Also, a literature study will be undertaken, including studies of stigmatization and mobilization of health resources in post-conflict settings. Finally, in each department a team of field staff coordinators and assistants will be identified and trained in basic research methodology, such as interviewing and data collection and management. Arrangements will be made in each district with agents, institutions and professionals to ensure engagement in the research process, including the possibility of participating in a research training curriculum certified by Universidad Externado (UE).

A one-year multi-donor project, involving provision of health care services (including mental health services) in 25 departments, will be implemented by the MoH in 2018. Synergy between this and the current project will be created by means of identifying relevant monitoring and evaluation (M&E) indicators, comprising routine data from the existing health information system.

The quantitative research component of the mixed-methods study will be based on proportional population samples from each of the five departments and will provide data on violence exposure, unmet physical and mental health needs, health-seeking behavior, service preferences, and social data, such as social capital as well as data in terms of belonging to vulnerable groups. According to the National Mental Health Survey (2015), the proportion of people with mental health problems during the last 12 months makes up around 36%. A comparable proportion (38,5%) has sought attention for a mental health condition during the last 12 months, and 94% of these (36% of the total) received such attention. In this study, a sample size of at least 500 per department (a total of 2500 in a population of approx. 5 million) will yield around 900 with a recent mental health problem (95% CI 892-907).

The qualitative research component will include two focus group discussions in each department, aiming for a qualitative, detailed understanding of views and needs and preferences of the target groups in terms of accessible and appropriate health services and obstacles for their usage. In addition, the qualitative component may include other qualitative data collection methods tested as appropriate for the context. In parallel, the existing health facilities and community support mechanisms and resources will be mapped using existing data in the MoH as well as data from the survey.

Once the data mentioned above have been collected, two workshops involving the three project partners will be organized. During the first workshop, all data collected will be presented and analyzed by project partners. Conclusions will be drawn as to needs and preferences of stigmatized groups, including ex-combatants, available resources in the communities and local health care services. During the second workshop, function and modalities of the pilot community health interventions to be tested will be identified. The intervention will address community factors and aim to increase the ability and willingness of the communities to absorb and support marginalized conflict victims. The development and implementation of an appropriate system for monitoring and evaluation of the pilot interventions will also be addressed in the second workshop, building on the analyses and studies undertaken.

This project is of the greatest strategic relevance for the government of Colombia including the MoH to face the challenges and opportunities provided by the armed conflict and the peace accord. UE has throughout many years addressed the needs of the conflict-torn communities and individuals and will through the project get the opportunity to participate in the development and implementation of main national strategies for reintegration of conflict victims and healing of the society as a whole.

All interviewees will go through a procedure for informed consent. Ethical approval for the research will be sought from DIGNITY's internal ethical committee, and from the Comité de Investigación y Ética Universidad Externado de Colombia. It will follow the rules and regulations for health research in Colombia set out in Resolución No. 008430 from 1993 and Resolución 2378 from 2008. The participation of the MoH in all project activities will further help guaranteeing that the project is at all times in compliance with official Colombian requirements regarding interventions and ethics.

7. Overview of the research plan

Phase	*Period*	*Task*	*Responsible*
Preparatory phase	1.1.18 – 30.6.18	Reviewing existing data and health information systems	MOH (DGN + UE)
		Identifying M&E indicators for the 25 department multi-donor project	MOH (DGN + UE)
		Literature study of stigmatization	DGN
		Survey planning	DGN (MOH + UE)
		Focus group planning	UE (MOH + DGN)
		Mapping of health and community resources in the selected Departments	UE + MOH
		Training of field staff	UE (DGN + MOH)
		Writing articles and reports	DGN + UE + MOH
Study implementation	1.7.18 – 31.12.18	Survey study implementation	UE (MOH + DGN)
		Qualitative component implementation	UE (DGN + MOH)
		Analysing quantitative data	DGN (MOH + UE)
		Analysing qualitative data	UE (DGN + MOH)
Conclusion phase	1.1.19 – 30.6.19	Workshop 1 (findings)	UE (MOH + DGN)
		Workshop 2 (interventions + M&E)	MOH (UE + DGN)
Pilot intervention phase	1.7.19 – 31.12.19	Pilot field interventions	MOH + UE
		Setting up monitoring and evaluation	DGN (MOH + UE)
M+E phase	1.1.20 – 30.6.20	Analysing quantitative M&E data	DGN (UE + MOH)
		Analysing qualitative M&E data	UE (DGN + MOH)
Reporting and follow-up phase	1.7.20 – 31.12.20	Writing articles and reports	DGN + UE + MOH

	Preparing for continuation/follow-up project	MOH (UE + DGN)

8. Organisation and management

The project will be carried out by three project partners: DIGNITY, the Colombian Ministry of Health and the private university Universidad Externado. They bring to the project different skills, competencies and experience. The MoH and the UE have a thorough knowledge of the Colombian society, population and health care sector as well as the contacts and the capacity to liaise with other relevant stakeholders. Furthermore, the MoH has experience in collecting and analyzing data-sets from population based studies, and the UE has experience in qualitative field research methods and specifically applying such methods in a conflict and post-conflict setting. DIGNITY adds its experience from post-conflict research and interventions and is well positioned to draw from Danish expertise, e.g. from the anti-stigma campaign *One of us*.

The three project partners met in Colombia for one week in July 2017 to identify and specify core elements of the project. During this week, it became obvious that all partners are committed to working on this project and that they bring to the table different types of expertise that can be of benefit to the project.

DIGNITY will be directly responsible towards the donor and thereby overall responsible for monitoring and reporting on project progress. However, decisions regarding the project will be made by the partners after tri-partite discussions. Regular meetings for all three partners will be held during DIGNITY's visits to Colombia and on skype. This modality of work has proven feasible during the formulation phase of the project. To further secure research and intervention progress, short monthly progress reports will be shared by the partners.

All project partners possess the managerial skills and a good track record of managing international projects.

A national project advisory committee will be established in Colombia comprising the project partners and other relevant agencies including *Centro de Memoria Histórica, Unidad de Víctimas, Agencia para la Reincorporación y la Normalización, Corporación AVRE* and other institutions with experience or projects dealing with mental health in Colombia, and the Danish Embassy in Bogotá. Also, in Denmark DIGNITY will invite for meetings with relevant Danish experts from *One of us*, experts doing stigma-related research in Denmark, and other relevant experts from and outside of the institution.

9. Capacity strengthening

The research capacity will be strengthened among all project partners. DIGNITY will add to its international research experience the transformation of needs assessment surveys into national intervention strategies and the evaluation of these. UE will add to its experience in mixed-methods research in mental health and to its ability to engage in partnerships with public and international institutions on the use of research results. The MoH will increase its capacity to engage with private and international research institutions when designing policies and interventions and its capacity to work evidence-based, and local health care providers will increase their capacity by being involved in the data collection.

The creation of an evidence-base for future interventions is at the core of the project, and this approach will show how evidence can be used for designing and producing research and interventions. The experience gained will serve the partners not only in this project, but also in other future actions. A natural part of this approach is to access and use scientific literature. DIGNITY counts with one of the world's biggest collections of torture-, trauma- and rehabilitation-related literature and has access to a variety of literature databases. In the project, use will be made of the library for comprehensive literature searches. As this is a publicly accessible library (also via internet), linking the MoH and UE to its services may also be of future benefit for the two institutions. If found feasible and needed, a training on literature search may be set up during the course of the project.

Junior researchers and university students will be linked to the project with the aim of securing that the experience gained will be not only for senior researchers but also for younger generations. The students will be invited to disseminate their knowledge and experience to fellow students at the university.

10. Partnerships

The MoH is in a unique position to identify any initiatives regarding mental health in Colombia, and due to the peace agreement, it is expected that there will be an influx of organizations wanting to work on this topic. The MoH has already identified and is indeed a partner of the multi-donor project mentioned in section 6, and points of collaboration have been identified. Any other relevant initiatives will also be analyzed with a view to establishing areas of collaboration and synergy.

The project partners will also seek collaboration with other research groups undertaking mental health research in Colombia. So far, very little has been done in Colombia on this topic due to the conflict, but it is expected that other groups will start working in the same field now that the peace agreement is signed.

The project partners will aim at presenting research results in international mental health conferences. Relevant conferences will be identified during the course of the project.
The private sector is already involved in the project through the university. Perspectives for future collaboration with the private sector include, when possible, involving private health care providers in the implementation of the project and presenting them with the results, and presenting health insurance companies with the benefits of good mental health interventions which may convince them to commission such services from their providers and thereby lower their long-term costs for mental health care.

11. Publication and dissemination strategy

The project will from the beginning strive for high visibility in the five departments selected as well as in the country as a whole. Stakeholders such as local institutions, agencies and professionals will be engaged in the research process as early as possible to promote local ownership and support.

Results from the research activities will be communicated in several ways: (i) Scientific articles, prepared by all project partners in collaboration, will be submitted to peer-reviewed journals in English or Spanish journals. At least five articles will be submitted during the project period. (ii) Reports of each step of the research process will be drafted in Spanish

language and disseminated to relevant stakeholders and published on the internet. (iii) Local and national media will be contacted pro-actively to promote media coverage of the project and of its progress and findings.

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