

A Review of the Transcultural Psychosocial Organization (TPO), the Community Mental Health Program in Rural Cambodia

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Summary

Starting late after a long period of civil war and genocide, mental health was made one of the priorities of the first Cambodian National Health Plan by the Ministry of Health in 1993. Since then, both government bodies and non-governmental organizations, especially those which have worked in the refugee camps along the Cambodian-Thai border, initiated, and later helped to provide mental health services both clinical and community work including training, throughout the country. Transcultural Psychosocial Organization (TPO) is one of the non-governmental organizations which provide community health services in remote communities of Cambodia, namely Pursat, Battambang, Banteay Meanchey and Kampong Thom Province.

The purpose of this paper is to review the mental health problems in rural Cambodia, and the interventions to deal with these problems. The results indicate that psychological interventions are very much needed among people living in the remote areas to enable them to care for themselves and their families. Resulting from past trauma, current poverty and other psychosocial problems, many of them are suffering from minor to severe psychiatric problems, such as Post Traumatic Stress Disorder (PTSD), depression, somatization, anxiety and so on. To deal with these, some individuals turn to alcohol and violence to mask the stress in their lives and to solve problems within the family as well as in the community. Interventions starting from raising awareness among the general population to individual intervention, and from initiating social support and psychotherapy to psychiatric treatment, are thus urgently needed.

From this point of view, more funding is needed to extend the work to other parts of the country and to give incentive to community resources and government general practitioners who are trained in basic mental health to sustain the work in the long run.

Situation of Mental Health Services in Cambodia

Before 1975, there was one mental asylum located on the outskirts about 12 km from the capital of Phnom Penh, named Prek Tnot Hospital. It was directed by French-trained Cambodian physicians providing mental health services to the entire population of the country, mostly inpatients. The hospital was closed and used as a prison during the Pol Pot regime¹ from 1975 to 1979. In 1979, after the Pol Pot regime was ousted, among the 43 surviving medical doctors in Cambodia, none of them were psychiatrists. At the same time, Prek Tnot hospital was reopened with the new name of Chey Chumneas Hospital,

¹ During the Pol Pot regime from 17th April 1975 to 07th January 1979, 1.7 million Cambodian people (about one-fifth of the country's population) died as a result of executions, starvation, illnesses without medical care and forced labor, including most of the intellectuals (Documentation Center of Cambodia).

and was used as a general hospital for Kandal Province.

According to Savin (2000),² from 1979 to 1992 there were no mental health services available in the country, except some services and short-time training courses on primary mental health care in the refugee camps along the Cambodian-Thai border. After the first national election organized by the United Nations in 1993, the socio-political situation seemed to be more stable and the reintegration process began, to move refugees from the Cambodian-Thai border camps into the rest of the country. In the same year, the first national health plan was established, and this made mental health one of its priorities. Some mental health services from the refugee camps set up services elsewhere in the country. The Dr. Marchel Charle Roy Foundation started child mental health services at the former Prek Tnot Hospital for Kandal Province; Harvard University's School of Public Health started mental health services in Siem Reap Province; the Transcultural Psychosocial Organization (TPO) started community mental health work in Kandal, Kampong Speu, and Battambang Provinces; and the Social Services of Cambodia started services in Kampong Speu Province.

In 1994, the Norwegian-funded Cambodian Mental Health Development Program, together with the Ministry of Health, International Organization of Migration and the University of Oslo, Norway, implemented a program to train ten Cambodian physicians and later ten Cambodian secondary nurses to be psychiatrists and psychiatric nurses. To coordinate the work, the Mental Health Coordination Subcommittee the Ministry of Health was formed and later became the National Program for Mental Health.

A 2001 NGO consultative group meeting on Cambodia stated that "the mental health system is not yet comprehensive or adequate, but planning steps have started" (NGO Consultative Group Meeting 2001). In 2000, the Coordination Subcommittee of the Ministry of Health initiated participatory discussions and planning between the organizations active in mental health to create a standardized mental health system, including inpatient, outpatient, and community-based services, human resource development, and a legal framework and mechanism for coordination between relevant ministries and organizations.

Methodology

The information for this paper was collected from four project sites where most of the work in villages away from provincial headquarters has been carried out. The author, a former TPO staff member who was a clinical supervisor from early 2004 till late 2007, used to visit each team to supervise and monitor field staff in all their activities. He also coordinated the training for government general practitioners on basic mental health care with the National Program for Mental Health, and helped to set up mental health clinics in those areas. Further information related to mental health in Cambodia has gathered from websites and other sources such as UNICEF and WHO.

² Dr. Daniel Savin's experience in Cambodia began in 1991, when he spent two and a half years as a psychiatrist in a refugee camp on the Thai-Cambodian border, and as a general physician in western Cambodia.

Problems and Community Mental Health

Affected by civil war from 1970 to 1975 and genocide from 1975 to 1979, the Cambodian people experienced great trauma, followed by psychological and mental health problems associated with the sense of hopelessness, helplessness, lack of confidence, mistrust and fear. The civil war between the Khmer Rouge and the government of Cambodia from 1979 to 1996 resulted in more traumatizing experiences, especially for people who lived in or near the front lines of combat. Experts say that the effects of trauma and the terrible events on the victims, whether experienced directly or witnessed, will last for years. Victims may still be suffering from severe symptoms, such as re-experiencing the events, flashbacks to what happened, and an inability to function normally in society. The 12- year follow-up study by Sack, Him and Dickason (1999) showed that when that generation of children grew up, the symptoms of Post Traumatic Stress Disorder (PTSD) and depression were still very high, affecting 50% and 47% of subjects respectively at the first interview in 1983-1984, 4 to 5 years after the event. By the fourth interview, 12 years after the Pol Pot regime, the percentages of individuals affected by PTSD and depression were very high, high at 35% and 34% respectively. Among those children, 14 subjects still had memories of the traumatic events, such as “I keep remembering the execution of my father”, “I was tied to a tree and tortured,” “I saw a cadre kill a baby by throwing it in the air...” Consequently, the psychological impact on individuals significantly impaired their productivity in the community, and as a result made them very poor. Without help, they will not recover. As stated by the WHO, five of the ten leading causes of disability are mental health problems (Table 1).

Cambodia is located in south-east Asia, bordering with Thai and Laos to the north, Vietnam to the east and south, and the Thai Bay to the south-west. Compared with the neighboring countries, Cambodia is the poorest country in the region. According to the World Bank (2005), the Gross Domestic Per capita was \$US 297 (with an exchange rate of \$US1=4000 Riel, the local currency), and with 34% of the population living below the poverty line. Life expectancy at birth was 51 years for men and 57 years for women, 20 years shorter than for the US and about 25 years shorter than for Japan. With a fertility rate of 3.9, the infant mortality rate was 143 per 1,000 live births and the maternal mortality rate was 437 per 100,000 deliveries (UNICEF and WHO, 2004 – 2005). With a population of 14,074,000 in a land area of 181,035 square kilometers, the country is less populated (74 per square kilometer) than its larger neighbors. Because most of the land areas is flat and suitable for agriculture, people live throughout the country. About 85% of the population lives in the rural areas earning their income mainly from agricultural work and small businesses after the rainy season (Table 2). This shows that the majority of poor live in the remote communities. Medical work at the grass roots level with this population is very important and badly needed.

Though the Paris Peace Accord was organized by the United Nations and followed by the first national election in 1993, the civil war between the government and Khmer Rouge still continued till 1996. Since then, the country has gradually become more stable and peaceful. Despite that, till today, the country still faces the major problem of poverty, particularly among people living in the remote communities, where many people are not psychologically stable.

Table 1. The top ten diseases making people disabled

All Causes	Total (Millions)	Percent of total
<u>Unipolar major Depression</u>	50.8	10.7
Iron-deficiency anemia	22	4.7
Falls	22	4.6
<u>Alcohol use</u>	15.8	3.3
Chronic obstructive pulmonary disease	14.7	3.1
<u>Bipolar disorder</u>	14.1	3
Congenital anomalies	13.5	2.9
Osteoarthritis	13.3	2.8
<u>Schizophrenia</u>	12.1	2.6
<u>Obsessive-Compulsive Disorder</u>	10.2	2.2

Source: World Health Organization (WHO), 1996

Table 2. Socio-demographic data for Cambodia, 2005.

Population	Percentage, Rate
Urban	15%
Rural	85%
Males	48.3%
Female	51.7%
Sex-ratio at birth (number of males for 100 females)	93.5%
Age group from 0 – 4 years old	11.0%
Age group from 0 – 14 years old	39.0%
Age group from 5 – 14 years old	27.0%
Age group from 15 – 49 years old	26.0%
Density per km ²	74

Source: National Health Statistic 2005

Within the complex social environment, with poverty (30% of landlessness due to ill health, Oxfam GB), lawlessness, lack of social connectedness, and the decline of morality, people are vulnerable to acting violently to express their anger and to solve problems. Domestic crimes, robberies, and human trafficking are big concerns for society. Beside this, within the family, violence is also common. According to the Project Against Domestic Violence³ (PADV), 16% of all women surveyed reported that they were physically abused by their spouses, and 8% of all women reporting abuse by their spouses resulting in injuries. More than 50% of reported injuries were head injuries. Therefore the second main concern in the community is domestic violence. Wherever it happens, females and children are mostly the ones who suffer seriously.

To mask the symptoms of depression or PTSD, individuals tend to use alcohol, just to be temporarily happy or to escape from stressful situations. The effect of alcohol is to suppress their worries, concerns, or fears, but at the same time alcohol can severely affect people's health, relationships within the family and their socio-economic status

³ PADV is a local NGO which, based on their finding in the survey, pushed the government to pass a law against domestic violence. Now this law has been implemented and is enforced nation wide.

at home, particularly when they are addicted to it. For example, drunken men tend to abuse their children or wives, or fight with neighbors following heavy drinking. From the victims' side, wives of alcoholic and abusive husbands tend to use alcohol as well to cope with fear, to mask depression and other burdens within the home, and to numb their senses while being beaten by their husbands. As could be observed in fieldwork, there is a close relationship between alcoholism and domestic violence and ultimately the whole family ends up in poverty. What concerns us the most is that, because of the bad example of drunken adults in the villages and the availability of alcohol without legal regulation, teenagers and young adults are deeply involved with and consuming alcohol in the communities. This too frequently creates a huge problem in the rural areas especially when there is a ceremony in a village, and bloody or sometimes fatal fighting takes place after.

In short, the three main problems mentioned above – psychosocial problems, domestic violence, and alcoholism – are common problems faced by the members of many communities. The negative consequences of socioeconomic problems and poverty can significantly affect people's psychology and social well-being, and in turn unhealthy minds and poor social relationship can severely cripple people's economic performance. This vicious cycle will never be ended, unless proper interventions are available to help them.

At the community level, there are some projects such as the Northwestern Rural Development Project (NRDP) and the Japan Fund for Poverty Reduction (JFPR), which support the rural poor in order to improve their living conditions.⁴ But unfortunately, after getting loans, grants or the necessary resources to start their businesses, many people could not manage financially and spent the money in the wrong ways, on gambling or alcohol, and could not initiate any work to generate an income. Therefore, psychological intervention is very much needed for them at the individual level as well as at the collective level, to build confidence and trust, to improve social relationship and connectedness, and to enable individuals and communities to understand their problems and find suitable and positive ways to deal with them.

Among the organizations involving in mental health are the Social Service of Cambodia (SSC) and Transcultural Psychosocial Organization (TPO) who have started their projects in communities, usually in the provinces, away from the city.

Established in 1995 as a branch of an international organization, TPO International Amsterdam, TPO Cambodia has continued to work actively in the remote rural areas and became a local NGO in 2000. From then it still continued to be funded by the International Organization for Development Co-operation (ICCO), based in Amsterdam, the Netherlands, till 2006. Since 2006, TPO Cambodia was funded by the European Commission, and started working in four provinces in the country, namely Pursat, Battambang, Banteay Meanchey, and Kampong Thom Province (see Figure 1). Supervision and administration provided by the main office in the capital Phnom Penh allow the team in each province to implement the project more smoothly in rural communities. Each team consists of a team leader, four to six core group members, and supportive staff. Of the project staff, most are psychologists, medical assistants, social workers, teachers, psychiatric nurses, general nurses, midwives, or village health workers. More than 50% of the staff have worked for the organization for more than 5 years.

⁴ ADB 2001. Report and Recommendation of the President to the Board of Directors on a Proposed loan to Cambodia for the Northwestern Rural Development Project. Manila.

Figure 1. TPO Operation Sites in Cambodia



Activities to Deal with the Problems

With its goals to improve mental health and psychological well-being among vulnerable individuals, and to enable groups to be aware and cope with their own psychosocial problems in order to become productive members of families and communities, TPO has arranged and implemented a wide range of activities, in ways to benefit the poor most. From general to specific, from collective to individual, and from raising awareness to psychiatric interventions, those activities are: (i) Social Context Assessment, (ii) Training Community Resources, (iii) Psychosocial Awareness, (iv) Self Help Groups, (v) Individual Counseling, (vi) Training in Primary Mental Health Care and Development of Mental Health Clinics, and (vii) Referral.

Social Context Assessment

Collaborating with local authorities such as village and commune leaders, TPO staff (team leader and core group members) go to the project sites, meeting with people to discuss the issues, concerns and problems arising in their villages. There are two steps in conducting the social context assessment: (i) meetings with village or commune leaders and other key persons in the village such as teachers, traditional healers, priests, fortune tellers, traditional birth attendants, health center staff if any, and the respected elderly in the villages, and (ii) meetings with ordinary people, on a different day. In these two meetings, staff facilitate the session and use guided questionnaires to initiate the discussion and

allow participation. From the meeting, a lot of information can be obtained including specific problems occurring in the villages, people's main concerns and measures so far to deal with the problems, local resources (materials and human) that can be used as assets, and any help from other organizations. This information is very useful for the organization to use in planning and implementing its activities.

Problems encountered: People, initially, expected only the material support that they used to get, particularly from the government prior to election time. They have a strong belief that if they had money they would be all right. The organization has to convince them to rethink the link between psychosocial problems, physical problems, work performance, productivity, and poverty.

Training Community Resources

The second step is to select two or three people from each village to be trainees or community resource persons for their village in the future. There are some criteria which they have to fit from both sides: the organization and villagers. The persons to be recruited have to be active, helpful, respected, popular or liked by most people in the village, and with the potential to learn to help their people in the future in problems related to mental health. At the same time, they have to have some education and literacy in order to learn the basics of mental health from the organization. The training is usually conducted within ten days in the community, focusing on psychosocial problems, stress, how to cope with stress, and common basic mental illnesses. After the training, trainees will be actively involved in the program during the project period and be resource persons for the villagers when the program ends. After the program personnel gradually withdraw and move to another area, TPO staff still keep track of community resources and activities to sustain the program by providing supervision, monitoring, and evaluation of what they have experienced and done so far.

Problems encountered: In the areas where civil war has recently ended, TPO finds it difficult to find people who can read and write of an appropriate age to become trainees. If they are literate, they are often too young to be trained to become resource persons to help others in the village. In the Cambodian context, it is unlikely that young people can teach, make suggestions, or counsel older people within the family or deal with village issues related to psychosocial problems. TPO then has to adjust its teaching methods and training materials with less use of written scripts. In any case, it is not easy to provide such training.

Psychosocial Awareness

At this stage, with the help from trainees, TPO staff organize and conduct psychosocial awareness sessions in the village, using leaflets, posters and flipcharts containing pictures to convey information on mental health issues to illiterate villagers and to make them understand. They also use simple local language to explain them to the villagers. Participating in this, individuals who have problems related to the issues raised in the awareness raising sessions can come to the trainees or the staff of the organization for help later. The meetings can also function as a case finding strategy, where the staff are

guided to severe cases by other villagers or trainees, of people that are not able to join the session.

Problems encountered: Psychosocial awareness raising is usually conducted only once or twice in each village, according to the number of villagers. Despite trainees trying to gather villagers to participate in the program, some of them are too busy, not interested, going somewhere for work, or not able to attend. To deal with this, at the end of the education campaign, the TPO staff distribute posters, leaflets and flipcharts to people to take home, with the hope that the rest of the members of the family who did not attend can learn from this.

Self Help Groups

Given psychosocial education, members of the community are able to reflect on themselves, and whether they have similar problems in their daily life. Those who have problems – psychosocial concerns, alcoholic problems, or domestic violence – are put in a group. Usually, those who have similar problem are put in a group together, in which they can share, discuss, and find solutions together. The groups meet once a week for around twelve weeks, in meetings conducted by staff to initiate discussions, and facilitated by trainees. Group member's problems may be raised and discussed to identify their causes and consequences, ways to deal with them, how they have tried to solve the problems so far and their outcome, and new strategies to overcome them. The number of sessions till completion can be flexible (less or more than twelve) according to the improvement of the group members. After the group meetings are over, four follow-up sessions are held over a period of one year, to review and monitor the progress of each group member.

“Though internal regulation is set at the beginning, irregular participation and dropping out before the completion of SHG are the most common problems faced while running the group. This is probably due to people being too busy to join the group every week, or because they have improved, or because there is no change after a few sessions. Another problem, mainly among the members of the alcoholics group, is that people tend to drink alcohol again when the group stops meeting.”

Individual Counseling

Villagers who suffer from severe psychological problems, or the ones who are not comfortable in joining self help groups, prefer individual counseling provided by counselors from the TPO staff. This kind of help seems to be convenient for some clients, because they receive direct intervention from a therapist, one-to-one at their home. On the other hand, the therapist also is able to understand the clients' problems better, since the environment where the clients live, their inter-household relationships with their family members, their living conditions, and their social interaction with neighbors tell them a lot. Usually counseling sessions are conducted from four to six times, according to the severity of the patient's condition and the progress made.

Problems encountered: Some clients miss counseling sessions because they have to go to work in the fields far away from home. Some clients lose interest with the slow

outcome of therapy, since they cannot see immediate results, unlike dealing with physical problems such as coughs and colds that can be relieved ten to fifteen minutes after taking medication. So they drop out of the program. The strategy usually employed by counselors is convincing and preparing clients from the beginning of the sessions, to make them understand their chronic problems, the process of psychological intervention, and to lower their high expectations. Through this, better involvement and participation by the clients can be achieved, and improvement can be made.

Training in Primary Mental Health Care and Development of Mental Health Clinics

Of the staff members, most of the team leaders and core group members are psychologists, social workers, midwives, or teachers. They are not able to provide psychiatric intervention to patients cases suffering from severe mental illnesses when they come across them in the communities. To fulfill the needs of the communities, TPO with the collaboration with the National Program for Mental Health, Ministry of Health, has organized a 10-day training program for general practitioners working at referral hospitals in these areas, covering basic mental health and common mental illnesses, including the skills to identify and treat these cases. After the training, TPO has helped them to set up mental health clinic by providing infrastructure and medication for one to two years, before handing over the responsibility to the government. In this way, all cases of mental illness identified in the villages can be referred there for psychiatric interventions.

Problems encountered: From the experience of the last year, among the referral hospitals in four provinces where TPO organized and provided training to general practitioners, only two were able to set up mental health clinics in their hospitals after the completion of the program. Of those two, only one was functioning well and kept contact with TPO. The willingness of the local general practitioners and the collaboration of the provincial health departments are the main factors determining the success or failure of the program.

Conclusion

The program seems to be successful in the sense that, first the staff reach the people at the community levels with the aim of gathering information relating to people's psychosocial problems, the resources available in the areas, and the efforts of people to get help psychologically. These inputs are essential to help the organization plan its operations, and establish interventions.

Second, the processes of indentifying the problems and assets in the communities involve the participation of the local people who clearly know their own problems before helping to plan and implement solutions. Starting from the perspective of the recipients is a great way to gain their attention and participation in the program. They can see their own problems, the ways to cope with them, and the benefits coming from the program.

Third, the program is focusing on raising awareness and primary prevention at the local level. Doing so, the program can reach and cover a large population which can benefit from the program at various levels, such as (i) awareness of psychosocial and mental health problems, (ii) solving minor problems by joining in self help groups and (iii) allowing smaller numbers of cases to receive individual counseling and psychiatric interventions.

Fourth, the community resources, the trainees, who get training and work with the organization for years, are a useful resource for the community in helping their own people at the primary level, such as running self help groups or providing simple individual counseling. They also can refer cases of mental illness they identify to the mental health clinics as well if necessary, after the organization withdraws from their areas.

Recommendations

While people's psychological functioning is impaired, they are not able to care for themselves or their family, and most of the time they are excluded from, or withdraw from, their communities. Without concern for and management of people's mental health, material support will be wasted, communities will never develop, and poverty will never be reduced. Therefore funding is very much needed to extend community work on mental health to other provinces in the country.

Currently, while the Khmer Rouge tribunal continuing, millions of Cambodian people are remembering their past traumatic experiences and, as a result, their psychological wounds will be to some extent recalled. This is the right time for mental health services to be provided to people, particularly in the remote areas where information from the media cannot reach. Doing so can protect victims against new trauma, and allow them to live peacefully, not taking revenge. It can also help the perpetrators to realize what they did in the past, in order to ask for forgiveness. If the work could covered most of the people in the country, forgiveness and reconciliation would happen in Cambodia peacefully.

From the side of the organization, the development of training programs which rely less on reading and writing skills are greatly needed to train community workers who themselves cannot read or write. Leaflets, posters and flipcharts should also be amended to include pictures and simplified messages that can be easily be understood by local people.

Incentives, as can be observed, are very important and needed to encourage trainees and government general practitioners to continue their work effectively, helping the poor. In this way, funding needs to be added to sustain the program and to keep benefiting the local people in the long run.

As the law against domestic violence has come into effect and is being enforced in the country currently, a law against the abuse of alcohol also needs to be established for everyone to follow. As mentioned by Schneider (2006) "from the public health perspective, it may be [more] efficient to try to change the social environment that influences people to behave in unhealthy ways than to try to change people's behavior [one] individual at a time." Therefore through working only with individuals alone without strengthening the law and social regulation, the outcome that can be expected is very limited, given that the relapse rate is high in the case of members of self help groups who are alcoholics.

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