Conflict, Disaster, Homicide
Mental health reform in post-conflict areas: a policy analysis based on experiences in Bosnia Herzegovina and Kosovo

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This policy analysis provides insight into the ongoing process of mental health reform and the difficulty of sustaining such reform in post-conflict areas. It is based on experiences in Bosnia Herzegovina and Kosovo in the former Yugoslavia.

This could be the first health policy analysis specifically on the subject of mental health reform in post-conflict areas.

Mental health reforms started in 1995 in Bosnia Herzegovina and in Kosovo in 1999, immediately following the end of armed conflict in these regions. As a result, there are now sufficient literature studies and experience available in both areas to make an initial evaluation and policy analysis.

Both areas were studied during various stages of the implementation of mental health reform, and because of this provided insight into the different phases of this ongoing process.

The insights provided by this study could have implications for things such as the development of strategies for improving the sustainability of mental health reform in similar situations in future.

Mental health problems account for five of the 10 leading causes of disability worldwide, which amounts to 12% of the total global burden of disease.1 In general, war-related disabilities (physical injuries) and mental disorders have an increasing impact on the global burden of disease. Projections for 2020 rank unipolar major depression and war-related disabilities in first and eighth place, respectively, in their impact on the global burden of diseases; in 1990 they ranked fourth and sixteenth.1

Mental health reform refers to a shift from institutional mental health care towards community mental health and mental health care. The WHO’s World Health Report 2001 showed worldwide interest in community mental health care, considered to be more cost-effective than institutional care. Care of this kind makes it possible to intervene early when mental disorders are developing, and to limit the stigma attached to treatment.2,3 This shift from institutional mental health care towards community mental health and mental health care marks an important change in the whole of Eastern Europe and the former Soviet Union.4,5

Mental health reforms in the post-conflict areas of Bosnia Herzegovina and Kosovo have specific characteristics and dynamics, and are taking place within the context of huge foreign donor influence, overall health care reforms and reform of health care financing systems.

There are many definitions of sustainability.6 Sustainability is defined here as a lasting, successful shift from a system where the main focus is on institutional, clinical mental health care to a system focusing on community mental health and integrated mental health care. The successful continuity of these new services also depends on cultural and financial characteristics.

The following examples illustrate the difficulty of sustaining mental health reform in Bosnia Herzegovina and Kosovo:

(i) Planned community mental health centres are being implemented slowly.7–10
(ii) The general public is unaware of the mental health reforms and does not understand them.6–10
(iii) There are increasing problems of economic access to mental health care and services.11–14

Materials and methods

Data collection

Literature study of ‘grey’ policy documents and articles on health policy (including mental health policy) in Bosnia Herzegovina and Kosovo was undertaken.

Policy documents were collected from many different actors such as the World Bank, several non-governmental organizations (NGOs) including Médecins Sans Frontières, HealthNet International (HNI) and the International Organization for Migration, the WHO, the United Nations High Commission for Refugees, key mental health and other health professionals and local ministries of health.

Key informant interviews

For Bosnia Herzegovina, key informant interviews took place in August 2001 with:

Various mental health and other health professionals (psychiatrists, psychologists, nurses and social workers) and patients in 15 mental health institutions, including university hospitals with psychiatric departments, psychiatric clinics, psychiatric wards of general hospitals and community mental health centres all over Bosnia Herzegovina;

Several NGOs (HNI, Medica Zenica, Vive Zene and War Child);

WHO office for Bosnia Herzegovina;

International Committee of the Red Cross;

Swiss Agency for Development and Cooperation, Coordination office Sarajevo, Embassy of Switzerland;

Assistant Minister of Human Rights of the state of Bosnia Herzegovina;

Assistant Minister of Human Rights of the state of Kosovo;

Entity Ministry of Health of the Republika Srpska.

For Kosovo, key informant interviews took place in March 2002 in Geneva with those WHO mental health professionals consulted on mental health reform in Kosovo. In addition, there were email contacts with mental health professionals working in Kosovo (in the Pristina university hospital and in...
community mental health centres) and with WHO support staff in Kosovo.

Data analysis
Walt’s analytical framework\(^{15,16}\) was used here to analyse the data collected in Bosnia Herzegovina and Kosovo. This framework distinguishes context, content and process, and the various actors involved in mental health reform. It is a systematic framework that can broadly analyse the implementation of health policies (including many disciplines and sectors); such a broad analysis is necessary here for evaluating mental health reform.

For the context analysis, data were collected on political history, the history of mental health services, psychiatric epidemiology, foreign influences, health care financing systems, medical anthropology and societal values.

For the content analysis, data were collected on principles of mental health reform and implementation characteristics (like the establishment of community mental health centres and education of mental health professionals).

For the process analysis, data were collected on the timing and pace of mental health reform.

For the actors (or stakeholders) analysis, Michael Reich’s initial political mapping\(^{17,18}\) was used within Walt’s framework to show political and other support for and opposition to the various actors in mental health reform in these highly complex, political environments.

Strategies to increase reliability and reduce bias
Data were collected through on-the-spot interviews and literature study. In particular, the interviews with local actors could prevent information bias by the literature, which is mainly oriented towards international donors.

A great deal of grey literature (all types of policy documents) was used, which is common practice for policy analysis. To strive for the maximum degree of reliability, triangulation of this qualitative information was done by double-checking information during the interviews and using information from various local and international sources with different interests. This triangulation resulted in further convergence towards the results.

Meta-analysis of the results detected the most important central theme: the role of foreign influence. This resulted in the main findings on the role of foreign influence in mental health reforms in post-conflict areas.

Results
The collected qualitative and some quantitative data from the interviews and available literature were structured within Walt’s framework. Tables 1 and 2 give the most important interview and literature data. The references cited within the tables refer to the relevant literature and Internet sources for each topic.

Table 1 shows the most important context analysis data for mental health reform in Bosnia Herzegovina and Kosovo.

Table 2 shows the most important content and process analysis data for Bosnia Herzegovina and Kosovo.

Figure 1 is explained more extensively because this figure’s characteristics are not as familiar in public health literature. Figure 1 shows political support for and opposition to different actors in mental health reform in Bosnia Herzegovina and Kosovo. The assessment of the amount of power per actor is interpreted from the interviews and policy documents.\(^{8–13}\)

The footnotes to this figure explain the characteristics of the relevant health ministries. In general, figure 1 makes clear the processes of decentralization, economic dependency and involvement of professionals in mental health and health policy. Informal networking between the actors and other micropower processes are beyond the scope of this analysis. A more extensive explanation follows to give more specific insights into the interpretation of supporting or opposing power for every actor.

In-depth explanation of figure 1
In Bosnia Herzegovina, international donors are very powerful because they are funding the reform in an economically unstable country. After decentralization, the National Ministry of Health lost power in terms of responsibility for the health care system (such as financing and determining the essential drug list). On the other hand, the Federation’s cantonal ministries and the entity ministry of Republika Srpska gained a great deal of power. Mental health professionals have a lot of power because they play key roles in implementing this reform and because some health professionals hold key positions in the different ministries. Some key mental health professionals oppose the reform, especially in Republika Srpska’s entity ministry and in a number of the Federation’s cantonal ministries. They prefer to maintain the pre-war institutional mental health care organization, and support further specialization of mental health care services, such as specialized clinics for patients with post-traumatic stress disorder (PTSD).

The public is not well organized (as in strong patient organizations), is not involved in policy making and so is not very powerful. Still, the public does have some power because they are the actual users of community mental health services.

In Kosovo, international donors are very powerful for the same reason as they are in Bosnia Herzegovina. In 2002, decentralizing health care responsibilities towards the municipalities existed only on paper.

Early in 2001, policy making and financial control of all health care was still a central responsibility of the United Nations (UN) Interim Administration Mission Kosovo Department of Health and Social Welfare. In 2002, this UN Department of Health started to transfer power to Kosovo ministries. From the beginning, mental health professionals have been heavily involved in drawing up the strategic plan for mental health reform in Kosovo; they reported no opposition to this.

Public power has the same characteristics as those mentioned for Bosnia Herzegovina.

Having all the data available in tables 1 and 2 and figure 1, triangulation and meta-analysis of these data resulted in further convergence towards the most important results on the identified central theme of foreign influence.

Summary of the most important results
The role of foreign influence was a central theme in many of the results.

The context and process analysis showed that both areas became UN international protectorates and financially highly dependent on foreign donor funding. As a result, they became economically and politically dependent on the international community.

The initiation, funding and also part of the operationalization of mental health reform was done by international organizations. For example, during the armed conflicts NGOs started new ambulatory emergency mental health services, and after the end of armed conflicts many NGOs entered the areas with their temporary ambulatory mental health activities focusing mainly on traumatization.

Western health care financing models (mixed public–private insurance models) were quickly introduced in Bosnia Herzegovina, and health care financing became highly dependent on foreign donor funding. Local health administrators had to work according to new Western principles of efficiency and cost-effectiveness.

The content analysis showed that many different mental health professionals were trained by a number of international
actors analysis confirmed the power of international donors was perceived by some actors as reform from initiation, funding and partial implementation by international NGOs (including Médecins Sans Frontières, Médecins du Monde) introduced ambulatory psychiatric cures and dealing with psychiatric emergencies.

During armed conflict there was loss and destruction of health care capacity. International NGOs (including Médecins Sans Frontières, Médecins du Monde) introduced ambulatory psychosocial emergency services.

After armed conflict ended, establishment of community mental health centres began.

3. Psychiatric epidemiology

Exact information is not available owing to problems within health information systems such as poor patient registration and under-reporting.

Several surveys showed a continued high incidence and prevalence of mental health disorders, a high prevalence of signs and symptoms of PTSD and showed both elderly and internally displaced persons to be high-risk groups for mental health problems, even several years after armed conflict ended.

4. Foreign influences on mental health reform

Initiation, funding and partial implementation by international donors was perceived by some actors as reform from outside.

Many NGOs created parallel systems of ambulatory mental health care, with unmanaged and overlapping activities focused on traumatization.

5. Health care financing system

Before armed conflict, there was a national health insurance plan and payroll tax.

After armed conflict:

In Bosnia Herzegovina, there was development of compulsory health insurance schemes, private, insurance schemes by law (although these were not operational), an increase in informal payments and some co-payments. However, the health care financing system relied heavily on donor funding.

In Kosovo, in 2001 there was as of yet no health care financing system and there was an increase in informal payments. The system also relied heavily on donor funding.

6. Anthropology and societal values

Local beliefs:

Users of mental health services were thought to be severely delusional and dangerous persons.

There was a reluctance to use mental health services owing to fear of bringing up painful memories.

Physical suffering was more acceptable as a reason for seeking health care.

There was a distrust of physicians from different ethnic backgrounds.

Dealing with mental suffering was more group- and family-oriented, and less of an individual responsibility.

Societal values:

Utilitarian values like efficiency and cost-effectiveness were introduced in a system with a health administration that was more familiar with centralised, bureaucratic principles.

Examples of these utilitarian values are the introduction of co-payments, and paying providers according to their outputs (patients treated) rather than to their inputs (number of beds).

organizations in the new concept of community mental health and mental health care.

The actors analysis confirmed the power of international organizations to provide political support for mental health reform and also identified the concept of decentralization of political health care responsibilities supported by the international community. Particularly in the Federation of Bosnia Herzegovina, drastic decentralization took place using a Swiss cantonal model, which resulted in many small cantonal ministries of health.

Discussion

Limitations of the method

The input of qualitative data from the literature used was comparable for both Bosnia Herzegovina and Kosovo.

The input of qualitative data from personal interviews differed between Bosnia Herzegovina and Kosovo.

Although extensive personal interviews were held with many actors in Bosnia Herzegovina, owing to practical limitations the same kind of personal interviews were not possible inside Kosovo. This may have affected the input of qualitative data for Kosovo. To reduce this difference, thorough personal interviews took place with those WHO mental health professionals who were consultants on mental health reform there, and e-mail contacts were established with key mental health professionals.

Discussion on the role of foreign influence

All these effects of foreign influence leave us with the following question: do they have a positive effect on mental health reform and its sustainability?

Foreign technical and economic support versus lack of local awareness and lack of local ownership. Clearly, foreign influence, with its technical, political and economic support, pushed the reform forward just after the end of armed conflict. In

Table 1 (Continued)

In Kosovo, in 2001 there was as of yet no health care financing system and there was an increase in informal payments. The system also relied heavily on donor funding.

<table>
<thead>
<tr>
<th>Population</th>
<th>Bosnia Herzegovina</th>
<th>Kosovo</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.36 million</td>
<td>1.89 million</td>
<td></td>
</tr>
<tr>
<td>Religions</td>
<td>40% Muslim</td>
<td>81% Muslim</td>
</tr>
<tr>
<td></td>
<td>31% Serbian Orthodox</td>
<td>10% Serbian Orthodox</td>
</tr>
<tr>
<td></td>
<td>15% Roman Catholic</td>
<td>9% Roman Catholic</td>
</tr>
<tr>
<td>Ethnic groups</td>
<td>40% Serbian</td>
<td>90% Albanian</td>
</tr>
<tr>
<td></td>
<td>38% Muslim</td>
<td>10% Serbian</td>
</tr>
<tr>
<td></td>
<td>22% Croat</td>
<td>3% Roma (‘Gypsies’)</td>
</tr>
<tr>
<td></td>
<td>1.5% Turkish</td>
<td></td>
</tr>
</tbody>
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particular, the foreign training of many different mental health professionals in the new concept of community mental health and mental health care was an important positive contribution to mental health reform. However, many years after the reform’s initiation the general public is still not aware of this new concept, and some mental health professionals perceive it as a reform from abroad. This public lack of awareness together with the perception by professionals creates a lack of local ownership for mental health reform. Obviously, this endangers the reform’s sustainability. Although it may be very difficult to change local beliefs on mental health-seeking behaviour and professional perceptions, the following two possible strategies could influence these firmly held beliefs and attitudes more successfully.

Possible strategies. First of all, there could be more methodical ‘marketing’. In other words, taking local beliefs into account when developing mental health promotion strategies for the new concept of community mental health and mental health care could result in more successful sustainability of mental health reform. Examples of such marketing within the Bosnian and Kosovar context are mental health promotion within family, school and religious networks, and integrating community mental health services into existing somatic health services. Also, more anthropological research on mental health-seeking behaviour patterns could help tailor mental health promotion strategies.

Secondly, the example of Kosovo showed that immediate involvement of local mental health professionals in strategic plans for mental health reform results in more sustainable reform. This is because local key mental health professionals will not perceive the changes as a reform from abroad, and will therefore be less likely to develop opposition to the reform in a later phase.

Temporary, and chaotic overlapping of, mental health activities

Considering the epidemiology with its high prevalence of PTSD, it was logical for the different NGOs to start mental health programmes that focused on this mental health problem. However, parallel and overlapping mental health activities (‘trauma businesses’) appeared that were unmanaged and chaotic. These were temporary, and because of this, endangered the sustainability of overall mental health reform, which includes all mental health problems.

Possible strategies. If NGOs better combined their mental health activities, with PTSD treatment as a first priority, with existing mental health and somatic health services now under reform, sustainable mental health reform would probably stand a better chance.

Privatization and increasing access problems

Introducing Western insurance models and privatization created increasing problems of access to mental and other health care. Private insurance schemes were implemented only by law, not in practise. Bosnia Herzegovina in particular did not seem to be ready for an insurance model. In 2001 Kosovo did not yet have a health care financing system, and even the World Bank suggested reintroducing the old national health insurance or tax model with payroll tax.

Possible strategies. Introducing a financing system closer to the original existing system and taking into account at what extent the area is ready for this could result in increased chances for both sustainable mental health reform and a more sustainable health care system in general.

Rapid, drastic decentralization and increasing access problems

The concept of decentralization promoted by many international organizations aimed at more local involvement was in part counterproductive, especially in Bosnia Herzegovina. It produced microbureaucratic procedures for many health care financing issues like insurance logistics. This created increasing access problems to mental and other health care. Local health care administrators used to centralized bureaucratic principles suddenly had to work from a decentralized, powerful position according to new utilitarian principles like cost-effectiveness and efficiency. One cannot expect a centralized East European post-conflict country to be immediately ready to switch to a decentralized Swiss cantonal model.

Possible strategies. Introducing decentralization less drastically at a local level and at a slower pace by well-trained administrators ready to take over responsibilities would probably
reduce the risk of additional access problems and increase local involvement and the chances for sustainability.

**Conclusions**

As shown by the examples of Bosnia Herzegovina and Kosovo, this policy analysis provides insight into the difficult policy and process of mental health reform in post-conflict areas. These examples show the difficulty of sustaining mental health reform several years after the end of armed conflict and the initiation of such reform.

This insight was gained by collecting all kinds of data (mostly qualitative, some quantitative) on many different topics and themes from many different sources from various political positions.

The method of analysis used—Walt’s framework together with Michael Reich’s political mapping—was a useful way to structure all these different and extensive qualitative data. This manner of structuring, along with ongoing triangulation and meta-analysis of the data, resulted in convergence towards the most important results, which follow here.

As illustrated by the examples of Bosnia Herzegovina and Kosovo, foreign influence in post-conflict areas appeared to be a central theme of these results. Foreign influence has the following effects on mental health reform and its sustainability:

- Foreign influence has a stimulating effect on the initiation of mental health reforms by introducing this new concept and by technical and economic support along with technical education.
- Foreign influence by various actors can threaten the sustainability of mental health reform in the following ways:
  1. by creating a lack of local ownership of the new concept of community mental health and mental health care;
  2. by creating chaos with many overlapping short-term mental health programmes (mainly dealing with traumatization);
  3. by forcing rapid changes in health care financing systems (such as privatization), and introducing new insurance models too rapidly; and
  4. by forcing rapid decentralization of health care responsibilities.

In conclusion, to achieve sustainable mental health reform, foreign aid provided in these difficult post-conflict situations has to achieve a balance between measured foreign influence and involving of existing local structures.
Key points

- This policy analysis provides insight into mental health reform and the difficulty of sustaining such reform in post-conflict areas.
- Foreign influence accelerates mental health reform in post-conflict areas, but can also threaten its sustainability in various ways.
- The insights help to develop strategies for studying and improving sustainability of health reforms in similar (post-conflict) situations.
- Walt’s analytical framework with Michael Reich’s political mapping is a suitable method to analyse health reforms in post-conflict areas.
- Foreign influence in post conflict areas can threaten health reforms by creating chaos and a lack of local ownership and by forcing quick privatization and decentralization.

References


7. Key informant interviews in Bosnia Herzegovina, August 2001: ministries, NGOs, mental health professionals, hospital directors, self-help groups and patients were interviewed in a semi-structured way.


10. Agani F, Urbina L. Strategic plan for mental health reforms in Kosovo, 21 December 2000. Elaborated upon by the Mental Health Task Force, with the support of the World Health Organization.


27. Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. JAMA 2000;284:569–77.


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